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84-1038

No. ———

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

MARIO DE MODENA, dba SIXTH AVENUE PHARMACY, *et al.*,
Petitioners,

v.

KAISER FOUNDATION HEALTH PLAN, INC., *et al.*,
Respondents.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,
Petitioner,

v.

KAISER FOUNDATION HEALTH PLAN, INC., *et al.*,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTION PRESENTED

Are purchases of drugs by subscription health care organizations purchases "by charitable institutions" of "supplies for their own use" and thereby exempt from the Robinson-Patman Act under the Nonprofit Institutions Act, even though the drugs are resold for home use in direct competition with neighborhood retail pharmacies?

LIST OF PARTIES

Parties to the proceeding in the United States Court of Appeals for the Ninth Circuit were as follows:

Mario DeModena, dba Sixth Avenue Pharmacy; Hillcrest North Pharmacy, De Anza View Enterprises, and The Apothecary Shop, Edwin Drucker, dba Mission Park Pharmacy; Robert W. Born, dba MacLay Drug Company; Wellington, Inc., a corporation; Jewell Pharmacy, Inc., a corporation; Eugene Elkin, dba Kustner's Medical Square Pharmacy, and WVP Corporation, plaintiffs in No. 83-5720.

Kaiser Foundation Health Plan, Inc., a California corporation; Kaiser Foundation Hospitals, a California corporation; Kaiser Foundation Health Plan, Inc., a Washington corporation; Kaiser Foundation International, Permanente Services, Inc., Southern Permanente Services, Inc., Permanente Services of Hawaii, Inc., The Permanente Medical Clinic, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan of Colorado, Inc., Colorado Permanente Medical Group, P.C., Kaiser Community Health Foundation, Ohio Permanente Services, Inc., and Ohio Permanente Medical Group, defendants in No. 83-5720.

Portland Retail Druggists Association, Inc., an Oregon nonprofit corporation, plaintiff in No. 83-5721.

Kaiser Foundation Health Plan, Inc., a California corporation; Kaiser Foundation Hospitals, a California corporation; Kaiser Foundation Health Plan of Oregon, a Washington corporation, and Permanente Services of Oregon, a California corporation, defendants in No. 83-5721.

The Medical Group and Permanente corporations are for-profit organizations.

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Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

Plaintiff retail pharmacies petition for a writ of certiorari to review a decision of the United States Court of Appeals for the Ninth Circuit.

OPINION BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit is reported at 743 F.2d 1388, and a copy is reprinted as Appendix A to this petition.

JURISDICTION

The decision of the court of appeals was filed on October 2, 1984. Issuance of that court's mandate has been stayed pending resolution of this petition. Jurisdiction of this Court is based on 28 U.S.C. § 1254(1).

STATUTORY PROVISION

The Nonprofit Institutions Act, 15 U.S.C. § 13c, provides:

> That nothing in the [Robinson-Patman Act] shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit.

STATEMENT OF THE CASE

The De Modena petitioners, owners and operators of retail pharmacies in California, and petitioner Portland Retail Druggists Association, Inc., an Oregon nonprofit corporation representing 67 retail pharmacies in or near Portland, Oregon, brought separate class actions against various of the respondents in the U.S. District Courts for the Central and Northern Districts of California under the Sherman and Clayton Acts (on which jurisdiction was based), alleging, among other things, that,

> (i) in violation of Section 2 of the Clayton Act, as amended by the Robinson-Patman Act, respondents were knowingly receiving discriminatorily low prices on purchases of over-the-counter and prescription drugs;
>
> (ii) such price discrimination was not justified by differences in cost of manufacture, sale or delivery resulting from differing methods or quantities of respondents' purchases; and
>
> (iii) respondents, with others, had acted to conceal such price discrimination.

These two cases were consolidated for trial on the Central District of California. Prior to a hearing on the merits, the district court granted a motion to dismiss by the respondents, but was reversed by the Court of Appeals for the Ninth Circuit. 662 F.2d 641, reprinted as Appendix B to this petition. Following remand, the district court granted summary judgment for respondents, and the court of appeals affirmed, on the ground that respondents' drug purchases are exempt from the Robinson-Patman amendment of the Clayton Act by reason of the Nonprofit Institutions Act.

Respondents (listed on p. ii above), are a complex of interrelated organizations which provide prepaid medical and dental care, drugs and other products in nine states, including Oregon, California, and Washington. They constitute the largset single non-public purchaser of prescription drugs, and one of the largest non-public purchasers of over-the-counter drugs, in the United States. In 1977, the year petitioners filed their complaints, respondents' health plan in Oregon alone had 210,000 subscribers or 18% of the general population.[1] Of these subscribers 35% were also subscribers to respondents' drug plan.

Respondents operate pharmacies at hospitals and outlying clinics for the sale to the general public of over-the-counter and prescription drugs, as well as a variety of health-related consumer products usually sold in drug stores. During most of the period covered by the complaint these pharmacies were operated by Permanente Services of Oregon (in Oregon) and Permanente Services, Inc. (in California), both of which were for-profit corporations owned equally by Kaiser Foundation Health

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[1] In Northern California, comparable figures were 1,417,000 subscribers constituting 24% of the general population. Under the coverage of many subscribers, additional family members are included.

Plan, Inc. and Kaiser Foundation Hospitals. Because of the discriminatory prices received by respondents (including the Permanente Clinics, partnerships of physicians in private practice for profit), they are able to offer drugs to the non-hospitalized at prices substantially below those paid by competing neighborhood pharmacies, with a resulting loss to the public of many such pharmacies.

DECISION OF THE COURT BELOW

The court of appeals equated the retail pharmacy operations of respondents to charitable institutions, such as schools, colleges, universities, public libraries, churches, and hospitals. The court concluded (erroneously, we would submit) that, since some of the respondents are non-profit organizations, and that organizations which "promote health" are considered charitable under the law of trusts and are exempt from income taxes as charitable institutions, all of the respondents are "charitable institutions," as the term is used in the Non-profit Institutions Act. The court of appeals held that drug purchases of the respondents are purchases by a "charitable institution." The court further held that such purchases are "purchases of their supplies" for "their own use," as these terms are used in the exempting statute, even though the drugs are resold to the general public. The court dismissed petitioners' actions as to all respondents, except as to "sales of drugs to non-members." [2] The court of appeals would treat all members of the general public as "members" if they have subscribed to a medical or health plan even though they have not subscribed to an optional drug plan.

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[2] As to these sales, the court of appeals would remand for determination whether such sales are "a de minimis violation." Appendix, page 15a, below.

REASONS FOR GRANTING THE WRIT

1. The case presents an important question of federal law because the answer will preserve or destroy nationwide competition in the supply of drugs for home use.

Whether mass purchases by respondents of drugs which are resold to individual purchasers for home use are "purchases of their supplies for their own use" by respondents is an important question because of the need to preserve competition between alternate methods of health care supply in the United States, that between the fee-for-service method of health care, (in which a consumer pays a separate charge for each medical service or drug), and the subscription method, in which the consumer transfers some of the risk to the contractual health plan corporation by paying a fixed monthly charge in return for which services and drugs are provided as needed. This competition, especially that of neighborhood retail pharmacies, gives the consumer a variety of alternative sources of medicines at convenient locations and hours of service.

The decision of the court below, concluding that purchases of drugs by the respondents at discriminatory prices are purchases of their supplies for their own use even though resold for home use, does not leave to a free market the competition between pay-as-you-go drug purchase and contractual pre-payment plans. Rather, it makes a policy decision destructive to further competition between the competing methods, since it exempts the prepayment method from the federal prohibition against inducement or knowing receipt of discrimination not justified by cost savings and would deprive the public of the continuing benefits of such competition, including the convenience of neighborhood pharmacies. As alleged in the Portland Association's summarily dismissed complaint, the price discrimination (and its inducement) exempted by the decision of the court below from the prohibitions of the Clayton Act has "resulted in the failure of numer-

ous retail or community pharmacies in the states of California, Oregon and Washington" and, if the discrimination continues, it "will result in the failure of an additional and substantial number" of such pharmacies in those states.

The decision below also favors the subscription method over nonprofit hospitals, even including governmental hospitals, since the latter are subject to the limitations of *Abbott Laboratories v. Portland Retail Druggists Ass'n.*, 425 U.S. 1 (1976), reprinted as Appendix C to this petition, page 30a. In that case this Court held that drug purchases of hospitals used to refill prescriptions, to supply hospital medical staff for resale in private practice, or for sales to customers not being treated at the hospital are not "purchases of their supplies for their own use."

2. This question has not been settled by this Court.

Whether purchases of drugs by a subscription health scheme, not itself organized for profit but affiliated with individuals and organizations acting for their own profit, should be regarded as "purchases of their supplies for their own use" by a "charitable institution" even when the drugs are resold at the same functional level as neighborhood pharmacies to a broad spectrum of the general public, has not been settled by this Court. There is an obvious need for a definitive construction of these terms in the Nonprofit Institutions Act. As the court below acknowledged, there is "little law" in this area, and "the only relevant case" is the *Abbott* case. (See p. 7a of Appendix A.) That case dealt with purchases of drugs by nonprofit hospitals and held that some such purchases are "purchases of their supplies for their own use" and some are not, depending on how the drugs are used. The case did not involve subscription health plans or their purchases of drugs for resale.

3. The decision of the court below is in conflict with the only relevant decision of this Court, which limited the exemption to exclude resales in competition with neighborhood pharmacies.

In the *Abbott* case, the Court found "nothing in the [Nonprofit Institutions] Act that indicates that its exemption provision is to be applied and expanded automatically to whatever new venture the non-profit hospital finds attractive in these changing days. The Congress surely did not intend to give the hospital a blank check." 425 U.S. at 13. The Court distinguished ten different categories of use, declaring some for the hospital's "own use" and some "on the other side of the line that divides that which is in the hospital's 'own use' from that which is not." 425 U.S. at 15. The decision of the court below in this case would permit any hospital to step over this "line," as the respondents did here, by forming a subscription organization to buy the drugs, and it would handicap any competing hospital (charitable, nonprofit or otherwise), which failed to do so, since such hospital remains subject to the restrictions of the *Abbott* decision. The decision of the court below conflicts with this Court's opinion in the *Abbott* case and with the national health policy that competition and consumer choice are to be favored. *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 392 (1981). See, also, *Jefferson County Pharmaceutical Ass'n., Inc. v. Abbott Laboratories*, 460 U.S. 150 (1983).

Although this Court's decision in the *Abbott* case did not settle the question presented by this case, it pointed in another direction from that selected by the court below, which would exempt all purchases of drugs by pre-paid subscription corporations resold to the corporation's subscribers, (even if they do not subscribe to the corporation's drug plan), regardless of where, when, or what use is made of the drugs or of the competitive con-

text in which such resale takes place. In declining in the *Abbott* case to exempt purchases of hospitals used to refill prescriptions, to supply hospital medical staff for resale in private practice, or for sales to customers not being treated at the hospital, this Court concluded that the exemption provision of the Nonprofit Institutions Act is "a limited one" (425 U.S. at 14), and emphatically refused to deprive of all meaning the phrase "purchases of their supplies for their own use," as the court below has done in this case.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Nos. 83-5720, 83-5721
DC No. CV 77-5-IH

MARIO DE MODENA, dba SIXTH AVENUE PHARMACY, *et al.*,
Plaintiffs-Appellants,
v.

KAISER FOUNDATION HEALTH PLAN, INC., *et al.*,
Defendants-Appellees.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,
Plaintiff-Appellant,
v.

KAISER FOUNDATION HEALTH PLAN, INC., *et al.*,
Defendants-Appellees.

[Filed Oct. 2, 1984]

On Appeal from the U.S. District Court
for the Central District of California
Hon. Irving Hill, Senior U.S. District Judge, Presiding

Argued and Submitted November 7, 1983

Before: BROWNING and NORRIS, Circuit Judges, and KING, District Judge.*

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* Honorable Samuel P. King, Chief U.S. District Judge for the District of Hawaii, sitting by designation.

OPINION

NORRIS, Circuit Judge:

I. FACTS

Appellants are retail pharmacies located in Oregon and California. Appellees are the related corporations—including regional health plans, regional medical groups, and non-profit hospitals—that make up the Kaiser-Permanente Medical Care Program.

Appellees provide health care in a manner substantially different from the traditional fee-for-service method of health care in which a consumer pays a separate charge for each medical service or good provided by the doctor or hospital. The regional Kaiser Health Plan (HP's) contract with consumers who wish to become members and provide them with medical care in return for monthly dues. Each HP provides this care through two related organizations: Kaiser Foundation Hospitals, a California non-profit corporation which operates the Kaiser hospitals, and one of the eight regional Permanente Medical Groups. In addition, the HP's provide intersted members with a "drug plan." Under this plan, for an additional monthly charge, members obtain the right to purchase drugs at little or no cost. They can purchase these pharmaceuticals at a Kaiser hospital or at a pharmacy at a non-hospital location operated by an HP.[1]

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[1] Before 1977, the Kaiser appellees were organized in a slightly different manner. The pharmacies located outside of the hospitals were not operated by the regional HP's but by regional Permanente Service Corporations. These nonprofit corporations were formed because the Internal Revenue Service stated that the regional health plans would not be considered charitable organizations under the Internal Revenue Code if they ran the pharmacies. The Permanente Service Corporations, however, returned all receipts to the HP's less costs and a rate of return on capital. The Service

In this antitrust action, appellants advance three discrete claims concerning appellee's provision of drugs to HP members. First, they argue that appellees violated the Robinson-Patman Act, 15 U.S.C. § 13, by buying drugs at discriminatorily low prices from pharmaceutical companies and dispensing these drugs to HP members. Second, appellants maintain that appellees are attempting to monopolize the retail drug market in violation of section 2 of the Sherman Act, 15 U.S.C. § 2. Third, they contend that appellants violated section 3 of the Clayton Act, 15 U.S.C. § 3, by tying the sale of drugs to the sale of other health services.

Appellees moved for summary judgment below, and the district court granted the motion on all three claims.[2] Appellants then brought this timely appeal).

Corporations paid taxes on the amount allocated for rate of return on capital and then paid the amount remaining to the HP's.

In 1977, the Internal Revenue Service declared that its denial of charitable status to health plans which operated pharmacies was erroneous. The Service Corporations were then disbanded and control of their pharmacies transferred directly to the HP's.

Because the Internal Revenue Service stated that the Service Corporations should have been treated as charities for purposes of the Internal Revenue Code and because the Service Corporations engaged only in activities that the HP's currently engage in, we believe the analysis under the Robinson-Patman Act for sales by the Service Corporations is the same as that for sales by the HP's. Consequently, we will treat all sales at pharmacies located outside Kaiser hospitals as being sales made by the HP's even if some of those sales occurred before 1977 and were thus actually made by Service Corporations.

[2] Actually, the summary judgment before us is the second one granted by the district court in this case. We reversed the first one—granted in 1978—on the ground that appellants should have received additional time for discovery before the motion for summary judgment was granted. *Portland Retail Druggists Ass'n v. Kaiser Foundation Health Plan*, 662 F.2d 641 (9th Cir. 1981). On remand, the district court permitted discovery for as long as appellants requested.

II. THE ROBINSON-PATMAN ACT CLAIM

The district court ruled that appellees were not liable for violating the Robinson-Patman Act—even assuming they bought drugs at discriminatorily low prices—because they fall within an exception to that Act created by the Nonprofit Institutions Act.

The Nonprofit Institutions Act provides, "Nothing in the [Robinson-Patman Act] shall apply to purchases of *their* supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit." 15 U.S.C. § 13c. Appelles can thus qualify for this exception if they are 1) non-profit institutions; 2) eligible institutions under the Act; and 3) made the purchase in question for their "own use."

A

The HP's and Kaiser Hospitals are organized as non-profit institutions and would thus appear to meet the Act's requirements. Appellants argue, however, that these institutions are not really non-profit because they are controlled by Permanente Medical Groups, which are for-profit corporations consisting of doctors who provide medical care for members.[3]

We disagree. Both the Internal Revenue Service and the district court found that the Medical Groups do not exert control over the HP's, and given the financial arrangements between the Medical Groups and the HP's,

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[3] As already indicated, appellants assert a Robinson-Patman Act claim against all appellees, including the regional Permanente Medical Groups. The Medical Groups, however, do not sell drugs to members. Rather, they prescribe drugs which members purchase at one of the pharmacies operated by either an HP or Kaiser Hospitals. Because the Robinson-Patman Act governs only those who buy and sell at discriminatorily low prices, and not those who indirectly benefit from such purchases, *see* 15 U.S.C. § 13(a), appellants' claim against the Medical Groups must fail.

we believe that this conclusion is persuasive. The Medical Groups do not set their own fees. The HP's pay the Medical Groups an agreed upon amount per member per month, and this amount does not vary with the volume of service the group provides to the membership.[4] This fact greatly limits the amount of control the Medical Groups can exercise over the HP's. That the HP's and Kaiser Hospitals must fulfill their need for certain medical services by contracting with doctors who seek a profit does not make the HP's and Kaiser Hospitals themselves for-profit organizations.

B

We next consider whether the HP's and Kaiser Hospitals are eligible institutions under the Nonprofit Institutions Act. With respect to Kaiser Hospitals this question is easily answered. The Act explicitly lists hospitals as eligible organizations. In the case of the HP's, however, the answer is not as simple. The Act does not explicitly list HP's. Thus, we must determine whether such organizations are charitable institutions within the meaning of the Act.

There is no case law concerning which institutions are considered charitable for purposes of the Nonprofit Institutions Act. There is, however, a substantial body of precedent defining the term charitable for purposes of the tax code and the law of charitable trusts. Because the drafters of the Nonprofit Institutions Act wished to protect the same eleemosynary institutions that are given

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[4] A small portion of the payment to the Medical Groups—generally around five percent of the total payment—does not depend solely upon the number of members in the Medical Group's region. This portion is withheld by the HP and paid to the Medical Groups only if appellees meet their yearly financial goals. This system of payment is designed to give the doctors in the Medical Groups an incentive to keep costs low, and it is required by regulations promulgated pursuant to the Health Maintenance Organizations Act. 42 C.F.R. § 110.104(b)(1)(v).

special consideration under the tax and charitable trusts laws, *see* S. Rep. No. 1769, 75th Cong., 3rd Sess 1. (1938); H.R. Rep. No. 2161, 75th Cong., 3rd Sess. 1 (1938), we believe it is appropriate to refer to these precedents here. Thus, we look to this body of case law for guidance in determining whether the HP's are charitable institutions within the meaning of the Nonprofit Institutions Act.

"The definition of the term 'charitable' has never been static and has been broadened in recent years." *Eastern Kentucky Welfare Rights Org. v. Simon*, 506 F.2d 1278, 1286 (D.C. Cir. 1974), *modified on other grounds*, 426 U.S. 26 (1976), *cited with approval, Abbott Laboratories v. Portland Retail Druggists Assn.*, 425 U.S. 1, 11 (1976) (concept of the non-profit hospital has expanded over the years). In earlier times, health organizations were recognized as charitable only if they were supported primarily by donations and used those donations to provide health care for the indigent. *Id.* With the emergence of social welfare, insurance, and municipal hospitals, however, the number of poor requiring free or below cost medical services was drastically reduced. This reduction eliminated the rationale upon which the traditional, limited definition of charitable was predicated, resulting in a move towards a less restrictive interpretation of the term in recent years. *Id.* at 1288-89. Now all non-profit organizations which promote health are considered charitable under the law of charitable trusts. *Restatement (Second) of Trusts* § 368, at 246 (1959); G. Bogert & G. Bogert, *Law of Trusts* § 62 (1973). Further, a number of courts have specifically held that health maintenance organizations, such as the HP's, are charitable institutions for tax purposes. *Sound Health Ass'n v. Commissioner*, 71 T.C. 158, 177-81 (1970). Indeed, both the HP's and Kaiser Hospitals are exempt from income taxes as charitable institutions. Given this increasingly liberal interpretation of the term, we conclude that the

HP's are charitable institutions within the meaning of the Nonprofit Institutions Act.

C

Finally, we must determine whether the purchases here in question were made for the HP's and Kaiser Hospitals' "own use." [5] Appellants contend that the HP's and Kaiser Hospitals purchased drugs not for their own use, but for the use of others, namely their members. Appellees contend, by contrast, that what they purchase for the use of their members is purchased for their "own use" within the meaning of the Act.

The "own use" issue is conceptually the most challenging aspect of this case because there is so little law in this area; the only relevant case is *Abbott Laboratories* v. *Portland Retail Druggists Ass'n*, 425 U.S. 1 (1976). In *Abbott Labs*, the Court addressed the question whether sales of drugs purchased at discriminatorily low prices by non-profit, fee-for-service hospitals—hospitals which were not part of a health maintenance organization such as Kaiser—were exempt under the Nonprofit Institutions Act.

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[5] At this point, we can treat the HP's and Kaiser Hospitals as one organization for analytical purposes because whatever is in the "own use" of one part of a health maintenance organization would be in the "own use" of another. After all, whether a member purchases his drugs from a pharmacy run by a regional HP or one run by Kaiser Hospitals doubtless depends on the fortuity of which location is more convenient for the member.

Appellants argue, in effect, that we cannot consider the interest of Kaiser Hospitals in serving members because membership is a matter between the consumer and his regional HP and because the HP's and Kaiser Hospitals are distinct corporations. Appellant's Opening Brief at 12. But appellants have misapprehended the legal relevance of corporate structure. The cases they cite merely stand for the proposition that the presence of two or more corporations acting together is sufficient to satisfy the "combination, contract, or conspiracy" requirement which triggers the substantive provisions of section 1 of the Sherman Act.

In resolving this question, the Court was torn between two competing concerns. On the one hand, the Court was interpreting an explicit exemption from the Robinson-Patman Act that reflected Congress' desire to aid non-profit institutions even when those institutions fulfilled needs beyond those traditionally fulfilled by charities. *Id.* at 13. On the other hand, the Court reiterated the maxim that exceptions to the Robinson-Patman Act are to be construed narrowly and emphasized that this exemption in particular was not "to be applied and expanded automatically to whatever new venture the non-profit hospital finds attractive in these changing days." *Id.*

The Court resolved this tension by formulating a test which it found "inherent in the language of the statute." *Id.* at 14. Under this test, " 'their own use' is what reasonably may be regarded as use *by the hopsital* in the sense that such use is a part of and promotes the hospital's intended institutional operation in the care of persons who are its patients." *Id.* (emphasis in the original).

The Court applied this test to ten separate categories of drug sales. The Court exempted sales of drugs to in-patients, emergency room patients, and out-patients for use on hospital premises. The Court also exempted sales to both in-patients and out-patients for take home use, sales to hospital employees and students for their personal use or use by their dependents, and sales to the hospital's medical staff for their personal use or use by their dependents. The Court declined to exempt sales on prescription refills, sales to the hospital's medical staff for resale in private practice, and sales to walk-in customers who were not being treated at the hospital.[6]

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[6] The language of the Nonprofit Institutions Act speaks only to purchases by institutions for their own use. It says nothing about sales by such institutions. *Abbott Labs*, however, implicitly decided that whether an item purchased at a discriminatorily low

Appellants ask us to adopt the categorical rules set forth in *Abbott Labs* wholesale and apply them to this case. This suggestion, however, ignores the manner in which these rules were originally derived and would, if adopted, violate the spirit, if not the letter, of the Supreme Court's decision. In *Abbott Labs*, the Court generated its categorical rules by first determining the basic institutional function of a non-profit, fee-for-service hospital and then deciding which sales fit within this institutional function and which did not. Thus, to follow the true mandate of *Abbott Labs* we should not simply adopt the categorical rules set forth in that decision, but should instead determine the basic institutional function of the Kaiser-Permanente Medical Care Program and then decide which sales are in keeping with this function.

Health maintenance organizations (HMO's), such as Kaiser-Permanente, are designed to provide a complete panoply of health care to their members. *See* S. Rep. No. 129, 93rd Cong., 1st Sess., *reprinted in* 1973 U.S. Code Cong. & Ad. News 3033, 3040. *See generally II Report of the National Advisory Commission on Health Manpower* (1967). Whereas fee-for-service hospitals provide health care on a temporary and usually remedial basis to their patients, HMO's provide continuing and often preventive health care for their members. *See* 42 U.S.C. § 300e(b)(1)-(2) (describing a HMO's continuing obligations to its members). Given this extraordinarily broad institutional function, any sale of drugs by an HMO to one of its members falls within the basic function of the HMO. Consequently, we must conclude that drugs purchased by an HMO, such as Kaiser-Permanente, for resale to its members are purchased for the HMO's

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price was purchased for the institution's own use depends on whether and how the item was resold. *See generally* 3 E. Kinter & J. Bauer, *Federal Antitrust Law* § 25.9 (1983).

"own use" within the meaning of the Nonprofit Institutions Act and thus qualify for protection under the Act.[7]

We believe that this result is in keeping with the intent of the 75th Congress which drafted the Nonprofit Institutions Act. Although the exact intent of Congress is less than crystal clear from a reading of the legislative history, *see* Rosoff & Dunfee, A "Fix" for the Retail Pharmacy: The Supreme Court Redefines Application of the Robinson-Patman Act to Drug Sales by Nonprofit Hospitals, 13 Cal. W. L. Rev. 195, 203 n.35 (1977), at least one Justice has concluded that the Act was passed because "Congress was primarily interested in directly aiding nonprofit institutions by lowering their operating expenses, but not interested in indirectly aiding such institutions by providing them with the means of raising additional money." *Abbott Labs*, 425 U.S. at 23 (Marshall, J., concurring). If that principle is applied to this case,

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[7] HMO's, such as the Kaiser-Permanente, can therefore engage in some sales that would not be allowed if we applied the ten categorical rules formulated in *Abbott Labs* to this case.

For instance, in *Abbott Labs*, the Court held that fee-for-service hospitals cannot purchase drugs at discriminatorily low prices if those drugs are sold to refill a prescription, even if the original prescription was filled as part of an exempt sale. 425 U.S. at 15-16. It appears that the Court declined to exempt prescription refills because the basic institutional function of a fee-for-service hospital is to provide temporary medical care for its patients. Refilling prescriptions goes beyond that basic institutional function because it extends the relationship between the fee-for-service hospital and the patient into the indefinite future. *Id.* at 16 (A prescription is not for the hospital's " 'own use' forever just because it originated under hospital auspices. We conclude that the statute's limitation has been exceeded when the connection with the hospital has become as attenuated as it is at the refill stage.").

As we explained in text, however, the relationship between an HMO and its members is ongoing, not temporary. The relationship thus does not attenuate simply because the member stepped out the door of an HMO hospital some time ago. The HMO is consequently acting within its basic institutional function when it refills the prescription of a health plan member.

it supports a finding that all drugs purchased by an HMO for resale to its members fall within the Nonprofit Institutions Act. There can be no question that allowing HMO's to purchase drugs that are resold to members at lower prices directly helps the HMO by lowering the operating expense it must incur to provide this aspect of health care to its membership.

We also believe that a finding that drugs purchased by an HMO for resale to its members qualify for protection under the Nonprofit Institutions Act is in keeping with national health care policy. Under *Abbott Labs*, fee-for-service hospitals are exempted from the Robinson-Patman Act when they provide medicine to their patients. If we held that HMO's, such as Kaiser-Permanente, do not qualify for a similar exemption when they provide medicine for their members, fee-for-service hospitals would enjoy a market advandtage over HMO's. Congress passed the Health Maintenance Organization Act in 1976, however, to ensure that consumers have a free choice among various methods of obtaining medical care because Congress believed that this was the best way to lower the medical costs that consumers must bear. S. Rep. No. 129, 93rd Cong., 1st Sess., *reprinted in* 1973 U.S. Code Cong. & Ad. News 3033, 3039-40. Accordingly, we decline to interpret the somewhat open-ended language of the Nonprofit Institutions Act in a way which would impinge upon the free choice of consumers of medical goods and services.

Our conclusion that drugs purchased by HMO's for resale to members are purchased for the HMO's "own use" and thus qualify for protection under the Nonprofit Institutions Act does not dispose of appellants' Robinson-Patman Act claim, however. Appellees make some sales to walk-in customers who are not members of a Kaiser-Permanente HP. Under our analysis, those sales are not protected by the Nonprofit Institutions Act. Indeed, appellees concede that these sales are not for the HP's "own

use" and thus are not covered by the Nonprofit Institutions Act. Nevertheless, appellees argue that these sales should not be subject to the strictures of the Robinson-Patman Act because the sales are so minor as to be a de minimis violation of the Act. The district court agreed with the appellees, citing to the fact that appellees' sales of drugs to non-members constituted less than one percent of appellees' total sales of drugs.

We do not believe, however, that a court can determine whether or not certain sales are de minimis solely by reference to the percentage of an organization's total sales they constitute. The term de minimis generally refers to the effect of a violation, not to the proportion of a party's conduct which violates the law as compared to that which does not. One percent of appellees' total sales might amount to a substantial dollar volume with a dramatic effect on the ability of the relatively small retail drug stores to compete. We therefore remand this case to the district court for an evaluation of the impact of appellees' non-exempt sales on competition in the retail drug market.[8]

III. THE ATTEMPTED MONOPOLIZATION CLAIM

To establish a claim for attempted monopolization, a plaintiff must show that the defendant had a specific intent to monopolize the market, that there was a dangerous probability that the attempt might succeed, and that the defendant committed acts designed to achieve the illegal

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[8] Appellees contend that they would cease sales to nonmembers if they were certain that doing so would not subject them to liability for violation of state licensing law, state tax law, or state rules of tort liability. This record, however, is not nearly sufficient to demonstrate that the operation of these state laws immunizes appellees' conduct under the standard for antitrust immunity set forth in *California Retail Liquor Dealer's Ass'n v. Midcal Aluminum*, 445 U.S. 97 (1980). Nor have appellees made clear why closing the pharmacies to non-members would violate federal tax law, as they assert in their brief.

objective of creating a monopoly. *William Inglis & Sons Baking Co. v. ITT Continental Baking Co.*, 668 F.2d 1014, 1027 (9th Cir. 1981), *cert. denied*, 103 S.Ct. 57, 58 (1982).

We find that appellants failed to raise a genuine issue of material fact on the question whether the appellees engaged in acts designed to monopolize the market for retail drugs. The only evidence offered by appellants in opposing appellees' motion for summary judgment shows merely that the appellees drove hard bargains with pharmaceutical companies and obtained the best prices possible.[9] Appellants offered no evidence of predatory intent, such as proof that appellees coerced pharmaceutical companies into selling drugs to them below cost, or that appellees, in turn, sold drugs to their members below the cost of acquiring the drugs. Nor did appellants present any evidence that appellees coerced pharmaceutical companies into harming appellants. Accordingly, summary judgment was properly granted on this claim.

IV. THE TIE-IN CLAIM

To establish a tying claim, a plaintiff must first demontrate that the defendant is selling two distinct products as a package. He must then show that the defendant has sufficient power in the market for one product (the tying product) to encourage consumers to buy the other product (the tied product) when they might not ordinarily do so. *See Portland Retail Druggists Ass'n v. Kaiser Foundation Health Plan*, 662 F.2d 641, 648 (9th Cir. 1981).

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[9] To bolster their attempted monopolization claim, appellants filled their opening brief with references to an affidavit by Howard Steinbach. The district court ruled, however, that the information in that affidavit was not admissible because the affidavit contained nothing but conclusory statements and hearsay. We agree with the district court's ruling on this point and consequently do not consider the Steinbach affidavit.

Appellants claim that appellees have made three such tying arrangements. All of these arrangements involve the drug plan that appellees sell to members. The first alleged tying arrangement is between the drug plan (the tied product) and the basic health plan (the tying product). The second is the converse arrangement between the health plan (the tied product) and the drug plan (the tying product). The third is between the drugs sold at appellee's facilities (the tied product) and the drug plan (the tying product).

None of these contentions is meritorious. The first alleged arrangement is not an illegal tie-in because appellees do not require that one purchase the drug plan to obtain the health plan. Appellants have no standing to attack the second alleged arrangement because they are not competitors in the market for the tied product, health plans. *See Aurora Enterprise, Inc. v. National Broadcasting Co., Inc.*, 688 F.2d 689 (9th Cir. 1982) (only consumers and competitors in the market for the tied product have standing to bring suit). Nor can appellants succeed on their third contention because we have already rejected the theory that a drug plan and the drugs provided under that plan are separate commodities for purposes of the Clayton Act. *Klamath Lake Pharmaceutical Assn. v. Klamath Med. Serv. Bureau*, 701 F.2d 1276, 1288-90 (9th Cir. 1983), *cert. denied*, 104 S.Ct. 88 (1984).

C. CONCLUSION

In sum, we affirm the district court's grant of summary judgment with respect to the claim of attempted monopolization and the tie-in claim. We also affirm the district court's conclusion that drug purchases made by appellees for resale to their members are exempt from the Robinson-Patman Act under the exception created by the Nonprofit Institutions Act. We reverse, however, the district court's determination that appellees' sales of

drugs to non-members constituted a de minimis violation of the Robinson-Patman Act, and we remand to the district court for reconsideration of this question.

AFFIRMED IN PART, REVERSED IN PART, AND REMANDED.[10]

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[10] Appellants also made an emergency motion to strike portions of appellees' Excerpt of Record. We took this motion under submission with the rest of the case.

The portion of the Excerpt of Record which appellants wish to strike served as an important basis for the district court's factual findings in this case. It was thus proper for appellees to include it in their Excerpt of Record. Consequently, appellants' motion is denied.

APPENDIX B

UNITED STATES COURT OF APPEALS
NINTH CIRCUIT

Nos. 78-2465, 78-2466

PORTLAND RETAIL DRUGGISTS ASSOCIATION, *etc.*,
Plaintiff-Appellant,

v.

KAISER FOUNDATION HEALTH PLAN, *et al.*,
Defendants-Appellees.

Argued Dec. 3, 1980

Submitted Dec. 17, 1980

Decided Nov. 30, 1981

Appeal from the United States District Court
for the Central District of California

Before GIBSON,* SNEED and POOLE, *Circuit Judges.*

POOLE, Circuit Judge:

Several retail pharmacies, and a non-profit trade association to which some of them belong, appeal the orders of the district court disposing of all of their claims brought in two consolidated antitrust actions. We vacate the entry of judgment and remand for further proceedings.

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* Hon. Floyd R. Gibson, Senior United States Circuit Judge, for the Eighth Circuit, sitting by designation.

I

This litigation began as two separate suits, one filed in the Northern and the other in the Central District of California in January 1977. Each complaint is substantially identical and charges appellees with violations of three distinct antitrust provisions: (1) Section 2(f) of the Robinson-Patman Anti-Price Discrimination Act, 15 U.S.C. § 13(f), by knowingly inducing or receiving pharmaceutical suppliers; (2) Section 2 of the Sherman Act, 15 U.S.C. § 2, by attempting to monopolize the retail drug market; (3) Section 1 of the Sherman Act, by unlawfully tying health products and services for sale. Class allegations were pleaded.

The various appellees together make up "health maintenance organizations," operating under the Kaiser-Permanente Medical Care Program (Kaiser). A health maintenance organization, like the typical health insurer, in an actuarial sense spreads the financial cost of health services by charging each of its members annual dues. Unlike typical insurance, the organization itself provides health services. Among the services offered by Kaiser is a drug benefit plan which permits members to obtain pharmaceutical products from Kaiser-operated pharmacies on favorable terms. Existence of the plans, and their perceived effect on the retail pharmacy business of appellants, led to the two lawsuits.

On April 11, 1977, the Judicial Panel on Multidistrict Litigation consolidated these cases in the Central District of California where they were assigned to Judge Hill. On May 23, 1977, the court convened a status conference aimed at lending some procedural order to this complex litigation. That conference produced a pretrial order, filed by the court on July 26, 1977.

Initially, the pretrial order classified these cases as complex and directed them to be conducted pursuant to the *Manual for Complex Litigation.* Memorialized in the

order was Kaiser's intention to file with the court Fed.R. Civ.P. Rule 12(b) motions to dismiss on several grounds. Although these motions were not described in the order, the primary allegations asserted as grounds for dismissal (and those relevant on this appeal) were that: (1) Kaiser engages in the business of insurance and therefore enjoys antitrust immunity by virtue of the McCarran-Ferguson Act, 15 U.S.C. § 12012(b);[1] (2) Appellants' Robinson-Patman cause of action failed to state a claim because Kaiser is exempt from liability pursuant to the Robinson-Patman Price Discrimination Act, 15 U.S.C.§ 13c; (3) Appellants' attempt to monopolize cause of action failed to state a claim; (4) Appellants' tying cause of action failed to state a claim.[2]

The pretrial order indicated that the district court would first consider the 12(b) motions to dismiss at a hearing set for January 23, 1978. Assuming appellants' complaint should withstand these tests of is sufficiency, a hearing was then scheduled a week later on appellants' motion to certify a class which was to be shortly filed.

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[1] Section 2 of the McCarran-Ferguson Act, 15 U.S.C. § 1012, reads:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

[2] These characterizations of the motions are essentially Kaiser's.

The remainder of the order set out a briefing schedule. On August 1, 1977, Kaiser was to file the "Rule 12(b) motion and supporting papers based on the McCarran-Ferguson Act exemption and shall file [the] remaining Rule 12(b) motions without supporting papers." On November 1, 1977, Kaiser was to file supporting papers in connection with all the motions other than McCarran-Ferguson which it had noticed on August 1. Limited discovery was permitted by the order "relating to defendant's aforementioned Rule 12(b) motions and plaintiff's motion to certify a class."

As ordered, Kaiser filed its "Notice of Motion . . . to dismiss and to strike under Fed.R.Civ.P. Rule 12." Although styled a Rule 12 motion to dismiss, the final sentence provided: "To the extent matters outside the pleadings are presented to, and not excluded by the Court, the motions shal be treated as ones for summary judgment pursuant to the last sentence of Fed.R.Civ.P. Rule 12(b)."

Accompanying this motion was the "Affidavit of Scott Fleming in suport of defendants' Rule 12(b) motions and alternative motions for summary judgment." That affidavit is a general discussion of the Kaiser program organization and operations, including the drug benefit program. It was submitted pursuant to the discovery order as a supporting paper in connection with the McCarran-Ferguson motion.

The limited discovery authorized in the order proceeded. Appellants propounded interrogatories, took two depositions and obtained production of numerous Kaiser documents. In July, appellants returned to the district court seeking discovery of pricing information from Kaiser. The justification offered for the request was appellants' claim that if Kaiser did not receive significant discounts on drugs purchased, or received discounts only as to certain drugs, the case might be dropped or the

class of plaintiffs narrowed. The request for broadened discovery was denied; for purpose of all pending motions Kaiser conceded that it received price discounts.[3]

On November 1, 1977, Kaiser filed supporting papers in connection with the remaining motions noticed in August (other than McCarran-Ferguson). Although described in the August notice as motions to dismiss (except for the sentence mentioned above which reserved the possibility of conversion to summary judgment motions), the motions were now clearly labelled in the alternative: for dismissal or summary judgment. In addition, a second affidavit of Scott Fleming was filed dealing particularly with factual issues implicated by Kaiser's newly filed supporting papers.

Appellants responded to Kaiser's motions claiming surprise that matters beyond the pleadings were submitted and reiterating their understanding that only 12(b) motions were to be considered by the court. Nonetheless, two affidavits were filed, executed by Stanley Harman. One was tendered in specific response to the McCarran-Ferguson motion and the other related to the price and contract arrangements by which Kaiser acquired drugs from manufacturers.

The case came on for hearing before the district court on January 23 and 24. At the outset, the court announced that it was prepared to consider matters outside the pleadings in ruling on Kaiser's motions and would therefore proceed as though the motions were for summary judgment under Fed.R.Civ.P. 56. Appellants objected but the district court found that, since August, appellants had been fairly apprised that the motions before the court would be treated as for summary judgment, and that the three-month discovery permitted (until November 1) by the pretrial order was reasonable. The

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[3] Other discovery disputes which have marked this litigation need not be discussed in resolving this appeal.

court noted that adequate discovery had been conducted, particularly as to the McCarran-Ferguson defense, and appellants were unable to specify with particularity what additional discovery they needed to undertake.

The district court disposed of this case as follows: First, the court granted, in the alternative, Kaiser's motion to dismiss and entered summary judgment as to each cause of action, concluding that the McCarran-Ferguson Act exempted Kaiser from antitrust liability; Second, the court granted Kaiser's motion for summary judgment as to the Robinson-Patman cause of action (count one), concluding that Kaiser was exempt from liability by virtue of the Robinson-Patman Price Discrimination Act, 15 U.S.C. § 13c; Third, the court granted, in the alternative, Kaiser's motion to dismiss and entered summary judgment as to the claim of attempted monopolization (count two), concluding that appellants had failed to allege or create a material issue of fact revealing predatory conduct on the part of appellees; Finally, the court granted, in the alternative, Kaiser's motion to dismiss and entered summary judgment as to the tying claim (count three), concluding that Kaiser's health benefits amounted to one service and not the two required for a tying offense.

Appellants filed a notice of appeal to this Court and the case is now properly before us for decision. Appellants allege procedural defects in the grant of summary judgment and ask that we order the district court's judgment reversed on the merits.

II

Summary judgment may be properly entered when the record before the court on the motion reveals the absence of any material issue of fact and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56. Before summary judgment may be entered against a party, that party must be afforded both notice that the

motion is pending and an adequate opportunity to respond. Implicit in the "opportunity to respond" is the requirement that sufficient time be afforded for discovery necessary to develop "facts essential to justify [a party's] opposition" to the motion. Fed.R.Civ.P. 56; *see Program Engineering, Inc. v. Triangle Publications, Inc.*, 634 F.2d 1188, 1193 (9th Cir. 1980); *Lucas v. Bechtel Corp.*, 633 F.2d 757, 759 (9th Cir. 1980); *British Airways Board v. Boeing Co.*, 585 F.2d 946 (9th Cir. 1978).

Appellants contend that they were denied both notice that summary judgment motions would be considered by the district court and an adequate opportunity to develop facts crucial to opposing those motions.

A

Questions of adequate notice of a summary judgment motion typically arise when the district court announces its intention to consider matters outside the pleadings in ruling on what has been noticed by the moving party as a Rule 12(b)(6) motion to dismiss. When the district court looks outside the pleadings in evaluating a noticed Rule 12(b)(6) motion, the motion must be converted and treated as one for summary judgment under Rule 56. *See Lucas v. Bechtel Corp., supra*, 633 F.2d at 759. If the conversion occurs unexpectedly, the non-moving party is left at the disadvantage of being unprepared to respond; hence notice is required. *See, e.g., Costen v. Pauline's Sportswear, Inc.*, 391 F.2d 81, 85 n.5 (9th Cir. 1968). The primary vice of unexpected conversion to summary judgment is that it denies the surprised party sufficient opportunity to discover and bring forward factual matters which may become relevant only in the summary judgment, and not the dismissal, context.

In evaluating the adequacy of notice, this circuit has determined from the record whether the party against whom summary judgment was entered was fairly ap-

prised that the court would look beyond the pleadings and thereby transform the 12(b) motion to dismiss into one for summary judgment. *See, e.g., id.* In this case, the district court found that appellants were apprised that materials outside the pleadings would be before the court "at least" in August when Kaiser filed its notice of motions and its specific papers relating to the McCarran-Ferguson defense.

As to the McCarran-Ferguson motion, we agree that appellants were reasonably notified that matters outside the pleadings were to be considered in connection with the pending Rule 12(b) motion to dismiss; they were on notice that the three month discovery period should be used to met the affidavit submitted in connection with the August 1 McCarran-Ferguson motion.

That three month period was also sufficient to generate or develop facts relevant to the McCarran-Ferguson issue. Appellants conducted extensive discovery relating to this motion and submitted their own affidavit to the court. Denial of more time to conduct discovery relating to this motion was not an abuse of the district court's discretion. *See British Airways Board v. Boeing Corp., supra.*

As to Kaiser's other motions, by the terms of the pretrial order, Kaiser was not required to file supporting papers until November 1, 1977. It was only on that date that the appellants saw the facts Kaiser would rely upon in seeking judgment, as contained in the second affidavit of Scott Fleming and described in the moving papers.

But November 1 was also the date the pretrial order ended discovery. Thus, on the date appellants were fully aware of the character of Kaiser's motions, as they would be argued to the court, and notified in the second Fleming affidavit of many of the facts to be presented, discovery was no longer possible under the court's order.

We think this unusual predicament left appellants at an unfair disadvantage as to all of Kaiser's motions save

that in connection with the McCarran-Ferguson Act. That predicament, coupled with the need for caution in summarily adjudicating complex antitrust cases, *Poller v. Columbia Broadcasting System*, 368 U.S. 464, 473, 82 S.Ct. 486, 491, 7 L.Ed.2d 458 (1962), leads us to conclude that the entry of summary judgment was premature and that the case should be returned to the trial court with additional fact-seeking time.

We emphasize in reaching this conclusion that we express no view on the scope of discovery which should be afforded appellants on remand.[4] The court may exercise its sound discretion to limit the parties to investigation of factual issues critical to such motions for summary judgment which may be before the court or may hereafter be filed. We hold only that the defending party's opportunity to discovery should not be foreclosed by order of the court before the moving party has presented critical factual materials on which he intends to rely and against which a defense is to be mounted.

Because the procedure used to enter summary judgment on all but the McCarran-Ferguson motions did not provide an adequate opportunity for discovery, we vacate the entry of summary judgment as to all issues before the district court save that of the applicability of the McCarran-Ferguson antitrust exemption.

III

Premature entry of summary judgment does not taint certain of the district court's rulings dismissing appellants' attempt to monopolize and tying counts on the pleadings pursuant to Rule 12(b)(6) and finding Kaiser exempt from antitrust liability under the McCarran-Ferguson Act. We turn to these issues.

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[4] Appellants have submitted to us factual materials which were not offered in the district court. We have not considered these materials because our function is to review the record before the district court. It is not appropriate for counsel to try to build such a record in this court.

A

Since the district court decision, the Supreme Court has decided *Group Life Health & Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979). In that case, the insured entered into a pharmacy agreement with Blue Shield insurance company which allowed him to purchase drugs from Blue Shield approved pharmacies for $2.00; Blue Shield would make a further payment to the pharmacist. To become an "approved" pharmacy, the druggist had to agree that Blue Shield's contribution would be the direct cost of the drug to the drugstore. When these agreements between Blue Shield and approved pharmacies were challenged as violative of the antitrust laws, the McCarran-Ferguson defense was invoked. The Court agreed with the Fifth Circuit that the agreements between Blue Shield and the participating pharmacies were not the "business of insurance" so as to be exempt from most antitrust liability under McCarran-Ferguson.

As to appellants' first two causes of action, *Royal Drug* requires the conclusion that the McCarran-Ferguson Act does not apply. In these counts, appellants are challenging the contractual arrangements and conditions by which Kaiser acquires drugs from manufacturers, wholesalers and distributors. Conceptually, this is identical to the situation in *Royal Drug*. All that differs is that Kaiser distributes the drugs itself. But that makes no difference because the antitrust violation alleged stems from the arrangement by which Kaiser acquires the drugs.

As for the tying cause of action, appellants are challenging conditions Kaiser may or may not place on its relationships with members. Whether those conditions sufficiently partake of the "indispensable characteristic of insurance"—"spreading of risk," recognized in *Royal Drug* as essential for application of the McCarran-Ferguson defense, is a question which we cannot presently

decide. *Group Life & Health Ins. Co. v. Royal Drug Co., supra*, 440 U.S. at 212, 99 S.Ct. at 1073. When this case was argued in the district court an expansive perception of the "business of insurance" requirement prevailed in a majority of the circuit courts of appeals. *See, e.g., Proctor v. State Farm Mut. Auto. Ins. Co.*, 561 F.2d 262 (D.C. Cir. 1977). Kaiser conducted discovery and prepared its case based on that broad perception of the requirement and accordingly did not prepare itself for the subtleties of the defense now revealed by *Royal Drug. See* L. A. Sullivan, *Recent Antitrust Developments: Defining the Scope of Exceptions, Expanding Coverage, and Refining the Rule of Reason*, 27 U.C.L.A.L.Rev. 265, 288 (1979). Because the issue might well implicate factual matters which Kaiser did not have an opportunity [to] prepare, *id.*, we vacate entry of judgment on the third cause of action based on the McCarran-Ferguson defense and remand for consideration of this issue in light of *Royal Drug*.

B

The district court alternatively dismissed appellants' Sherman causes of action (two and three of the complaint) for failure to state claims. The court found that no amendments could be made to state claims.

Reviewing dismissals, we are limited to an examination of the complaint; must accept all allegations of fact as true; and resolve all doubts in favor of the pleader. *Ernest W. Hahn, Inc. v. Codding*, 615 F.2d 830, 834 (9th Cir. 1980). Mindful of the reluctance of federal courts to dismiss a case such as this on the pleadings, *Hospital Building Co. v. Trustees of Rex Hospital*, 425 U.S. 738, 746, 96 S.Ct. 1848, 1853, 48 L.Ed.2d 338 (1976), we proceed with the required review.

1.

Appellants' complaint alleges that Kaiser has attempted to monopolize the business of drug sales by coercing drug

companies, wholesalers and distributors to grant to Kaiser prices lower than those otherwise available to retail pharmacies. It is further alleged that Kaiser has resold drugs so obtained at prices less than those that could be charged by appellants, to the injury of appellants.

A section 2 attempt to monopolize claim contains three elements: (1) specific intent to control prices or destroy competition in some part of commerce; (2) predatory or anticompetitive conduct directed to accomplishing the unlawful purpose; and (3) a dangerous probability of success. *William Inglis & Sons Baking Co. v. ITT Continental Baking, Co.* 652 F.2d 917, at 931 (9th Cir. 1981); *California Computer Products, Inc. v. IBM Corp.*, 613 F.2d 727, 736 (9th Cir. 1979). While these elements are discrete, they are often interdependent. *Inglis, supra*, at 931.

The district court concluded that appellants had failed to allege predatory conduct: a required element of a section 2 claim. Fairly read, the complaint does allege coercive activities by defendants to obtain reduced prices and thereby attempt to gain a monopoly position in the retail drug market. Although the evidence of predation which appellants expect (or hope) to prove is not detailed, antitrust pleadings need not contain great factual specificity. *See, e.g., Hunt-Wesson Foods, Inc. v. Ragu Foods, Inc.*, 627 F.2d 919, 924 (9th Cir. 1980).

We find the allegation of coercive attempts to obtain specifically-reduced prices sufficient for this complaint to state a possible section 2 claim. It may be that the coercion appellants will prove is of a kind: (1) "forming the basis for a substantial claim of restraint of trade, or (2) conduct that is clearly threatening to competition or clearly exclusionary." *Inglis, supra*, at 933 n. 11. In some cases, "clearly exclusionary conduct" itself may provide the basis for a section 2 claim because it may generate inferences sufficient to satisfy the other elements of the attempted monopolization offense. *See id.*;

Hunt-Wesson Foods, Inc. v. Ragu Foods, Inc., supra, 627 F.2d at 925-26; *Gough v. Rossmoore Corp.*, 585 F.2d 381, 390 (9th Cir. 1978). At this pleading stage, it is not possible to test the conduct of Kaiser and determine whether such a section 2 case may have been made. It has been alleged and that is all that concerns us at this time.

2.

A tying agreement prohibited by section 1 of the Sherman Act exists if three criteria are present: (1) Two distinct products or services are in fact tied such that the products are offered as a single package; (2) The defendant has sufficient economic power in the tying market to impose restrictions in the tied product market; (3) The amount of commerce in the tied product is not insubstantial. *Fortner Enterprises, Inc. v. United States Steel Corp.*, 394 U.S. 495, 499, 89 S.Ct. 1252, 1256, 22 L.Ed.2d 495 (1969); *Moore v. Jas. H. Matthews & Co.*, 550 F.2d 1207, 1212 (9th Cir. 1977). Kaiser contends that no tie exists that appellants may challenge. The complainants allege that Kaiser tied

> the receipt or distribution of over-the-counter and prescription drugs to the purchase of health services from defendants, thus compelling persons receiving health services from or through defendant to obtain drugs from defendants or forego the benefits for which they or their employees had paid defendants.

There has been a good deal of confusion in identifying the tied products or services. For purposes of our review of the pleadings, the question is whether appellants could prove any set of facts under the pleadings which would state a section 1 tying claim. We think that this pleading may be fairly read to allege that Kaiser requires customers to buy its drug plan in order to obtain the health plan. That is a classic tie about which, if proved, appellants could complain and we therefore can-

not agree that, under no set of facts could they prove illegal tying.

IV

The judgment of the district court dismissing the second and third causes of action on the pleadings is reversed. Judgment for Kaiser on the first two causes of action, entered based on the McCarran-Ferguson defense is reversed. As to all other bases for the district court's decision, we vacate the judgment and remand this case for further proceedings consistent with this opinion.

APPENDIX C

CASES ADJUDGED

IN THE SUPREME COURT OF THE UNITED STATES

AT

OCTOBER TERM, 1975

No. 74-1274

Argued December 16, 1975—Decided March 24, 1976

ABBOTT LABORATORIES, *et al.*

v.

PORTLAND RETAIL DRUGGISTS ASSN., INC.

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

James H. Clarke argued the cause for petitioners. With him on the briefs were *William B. Crow, Garry P. McMurry, R. R. Bullivant, Walter J. Cosgrave, Jack L. Kennedy, Thomas M. Triplett, Robert R. Carney,* and *Barnes H. Ellis.*

Roger Tilbury argued the cause for respondent. With him on the briefs was *Henry Kane.**

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* *Richard J. Wertheimer* and *Cary H. Sherman* filed a brief for the American Hospital Assn. as *amicus curiae* urging reversal.

Briefs of *amici curiae* urging affirmance were filed by *H. R. Burnham* and *James Allen Main* for the Alabama Pharmaceutical Assn. et al.; and by *Arthur B. Hanson, W. Frank Stickle, Jr.,* and *Sidney Waller* for the American Pharmaceutical Assn. et al.

MR. JUSTICE BLACKMUN delivered the opinion of the Court.

The Robinson-Patman Price Discrimination Act (Robinson-Patman), adopted in 1936, 49 Stat. 1526, amending § 2 of the Clayton Act, 38 Stat. 730, in general makes it unlawful for one engaged in commerce to discriminate in price between different purchasers of like commodities where, among other things, "the effect of such discrimination may be substantially to lessen competition." 15 U.S.C. § 13(a). The Nonprofit Institutions Act, adopted only two years later, in 1938, c. 283, 52 Stat. 446, exempts from the application of Robinson-Patman "purchases of their supplies for their own use by schools . . . hospitals, and charitable institutions not operated for profit." 15 U.S.C. § 13c.[1]

This case concerns nonprofit hospitals' purchases of products at favored prices from pharmaceutical companies. The issue is the proper construction of the phrase "purchases of their supplies for their own use," as it appears in the Nonprofit Institutions Act, and the consequent extent the hospitals' purchases are exempt from the proscription of Robinson-Patman.

I

Petitioners are 12 manufacturers of pharmaceutical products. Respondent, an Oregon nonprofit corporation and assignee of more than 60 commercial pharmacies doing business in the metropolitan Portland, Ore., area, instituted this action against petitioners in the United States District Court for the District of Oregon for violations of the federal antitrust laws. Treble damages and injunctive relief were sought.

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[1] "Nothing in sections 13 to 13b and 21a of this title, shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, charities, hospitals, and charitable institutions not operated for profit."

The amended complaint asserted five causes of action. Only one of the five (the second) is presently before us.[2] In this claim the respondent alleged that in selling pharmaceutical products petitioners discriminated between nonprofit hospitals, on the one hand, and commercial pharmacies (regular drugstores), including respondent's assignors, on the other. As an affirmative defense, petitioners pleaded that their sales of pharmaceutical products to nonprofit hospitals were exempt from Robinson-Patman under the Nonprofit Institutions Act.

The parties engaged in discovery as to the nonprofit status and drug-dispensing practices of 14 designated metropolitan Portland area institutions that operate as nonprofit hospitals. Affidavits were obtained and filed. Petitioners, as defendants, pursuant to Fed. Rule Civ. Proc. 56(b), then moved for summary judgment on the amended complaint's second cause of action. App. 68.

The District Court, by an opinion delivered orally, ruled that all the designated institutions were nonprofit hospitals, and that their purchases of pharmaceutical products from petitioners were purchases of supplies "for their own use," within the language of 15 U.S.C. § 13c, and thus were exempt from the restrictions of Robinson-Patman. The court concluded, accordingly, that there was no issue as to any material fact with respect to the hospitals' nonprofit status or their use of the pharmaceutical products they purchased, and granted summary judgment in favor of the petitioners on the respondent's second cause of action. App. 278-288, 290-292.

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[2] Causes of action based on discrimination in sales to city, county, and state governments, and to the Federal Government (the third and fourth causes of action asserted in the amended complaint, Record 61-62) were dismissed for failure to state a claim. App. 292. A cause of action based on discrimination in sales to proprietary hospitals and commercial entities, and one that the alleged discriminations were the product of a conspiracy (the amended complaint's first and fifth causes of action, Record 52-61, 62-63), remain pending.

The District Court, *id.*, at 292, certified its judgment under 28 U.S.C. § 1292(b), and the United States Court of Appeals for the Ninth Circuit permitted the interlocutory appeal to be taken. The Court of Appeals, while rejecting respondent's contentions that the designated hospitals did not qualify for exemption under § 13c,[3] nevertheless vacated the District Court's judgment and remanded the case for further proceedings. 510 F. 2d 486 (1974).

Because of the importance of the issue in the context of the modern nonprofit hospital, with its expanding service to the community, as compared with hospital operations of some years ago, and because of the obvious need for a definitive construction of language in the Nonprofit Institutions Act,[4] we granted certiorari. 422 U.S. 1040 (1975).

II

The pertinent facts are not really in dispute. The petitioners, admittedly, sell their pharmaceutical products to the designated Portland hospitals at prices less than those that govern petitioners' sales of like products to the respondent's assignors who are commercial pharmacists in Portland. The respective hospitals in turn dispense the pharmaceutical products they have so purchased from the petitioners. The application of Robin-

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[3] The sole exception was Bess Kaiser Hospital. As to this institution, the Court of Appeals concluded that certain factors "appear to present disputed issues of fact," and that the "proper legal standard" for determining whether that hospital was " 'not operated for profit' " could not be developed "on the limited record" before the court. The issue, therefore, was to be resolved on remand. 510 F. 2d 486, 488 (1974). No review of this aspect of the Court of Appeals' judgment has been sought, and that detail is not before us. Neither are we confronted here with an issue as to the non-profit status, within § 13c, of the other 13 hospitals.

[4] See the same Court of Appeals' decision in *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F. 2d 212, cert. denied, 389 U.S. 898 (1967).

son-Patman to this situation is conceded except to the extent the exemption provision of the Nonprofit Institutions Act applies. The controversy, thus, comes into clear focus.

Each of the designated hospitals has a pharmacy. It is a separate department of the hospital. Its operation produces revenue in excess of costs. The net accrues to the hospital's benefit, is utilized for the institution's general purposes, and thus supports other activities of the hospital.

The District Court, App. 283-285, and the Court of Appeals, 510 F. 2d, at 489, each perceived various categories of dispensations by the hospital pharmacies of the pharmaceutical products purchased from petitioners. But the District Court, in sustaining petitioners' motion for summary judgment, observed that "the vast majority" of the products purchased (85% to 95%), namely, those for the bed patient and for the patient receiving treatment in the hospitals' emergency facilities, were "clearly" for the hopsitals' use, within the meaning of the Nonprofit Institutions Act, App. 283; that "out-patient treatment," whether "initial or repeated," was not outside that Act merely because there has been a "change in the distribution of health care" whereby the percentage of out-patient treatment increased since the statute was passed in 1938, *id.*, at 284; that "take-home drugs" were within the "clear meaning" of the statute, *ibid.*; that drugs furnished to employees, staff physicians, and other members of the staff, while presenting "some mild degree of question," nevertheless were "for the use of the hospital," *id.*, at 285; and that the situation with respect to walk-in patients was insufficient in amount to "justify withdrawing" the statute's exemption, *ibid.*

The Court of Appeals agreed that the inpatient and emergency facility situations "cover by far the greater part of hospital distribution," and that "such dispensing

of drugs in the course of treatment in the hospital is the hospitals' [*sic*] own use." 510 F. 2d, at 439. The court recited petitioners' asserted justifications for the other type of sales "as proper hospital functions": the need of the departing inpatient for take-home drugs; the continuation at home of the patient's treatment begun earlier in the hospital; the sales to employees as being pursuant to collective-bargaining agreements; the sales to students as being aspects of the hospital's educational programs; the sales to physicians as being perquisites of hospital staff membership; the limitation of walk-in sales to instances where, at the time, the needed drugs could not be obtained elsewhere; the hospital's position "as a center for the provision of a full range of health services"; and "a decent regard for the needs of the community." *Ibid.*

But, conceding that "distribution by the hospitals can be justified as a proper and useful community service and thus can be regarded as a proper hospital function," the Court of Appeals concluded that this was not necessarily "the hospitals' 'own use.'" Instead, said the court, hospital use under § 13c was limited to cases where the hospital can be said to be the consumer, that is, to those cases where the dispensation of drugs were to inpatients and emergency facility patients. The concept could not apply "to cases of resale by the hospital to a private consumer." Accordingly, as to such sales, the hospital may not acquire the pharmaceutical products "at an acquisition price that discriminates against local retail druggists." *Ibid.*

III

We, too, find it convenient to view the hospitals' sales and dispensations of the pharmaceutical products purchased from petitioners as falling into several categories.[5] We divide them as follows:

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[5] The record does not show that each of the designated hospitals made dispensations in each category. It does indicate that dis-

1. To the inpatient for use in his treatment at the hospital. For present purposes, we define an inpatient as one admitted to the hospital for at least overnight bed occupancy.[6]

2. To the patient admitted to the hospital's emergency facility for use in the patient's treatment there. A patient in this category may or may not become an inpatient, as defined in the preceding paragraph.

3. To the outpatient for personal use on the hospital premises. For present purposes, we define an outpatient as one (other than an inpatient or a patient admitted to the emergency facility) who receives treatment or consultation on the premises.

4. To the inpatient, or to the emergency facility patient, upon his discharge and for his personal use away from the premises.

5. To the outpatient for personal use away from the premises.

6. To the former patient, by way of a renewal of a prescription given when he was an inpatient, an emergency facility patient, or an outpatient.

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pensations in each category were made by the hospitals considered as a group. Some hospitals refused to make certain types of dispensations. It would serve no useful purpose for us to describe the extent to which each individual hospital made dispensations in the several categories.

[6] A patient admitted for overnight bed occupancy, in the estimation of the several affiants whose affidavits appear in the record, clearly is an "inpatient." Some would carry the description further to include a patient admitted only for day surgery, or one who remains 12 hours or more, irrespective of overnight bed occupancy. In view of our disposition of the case, these distinctions are of no consequence here.

7. To the hospital's employee or student for personal use or for the use of his dependent.[7]

8. To the physician who is a member of the hospital's staff, but who is not its employee, for personal use or for the use of his dependent.

9. To the physician, who is a member of the hospital's staff, for dispensation in the course of the physician's private practice away from the hospital.

10. To the walk-in customer who is not a patient of the hospital.[8]

This division into categories reveals, of course, that we are concerned with linedrawing. The demarcation is somewhat simplified, on this record, by a concession on the part of the respondent. The respondent agrees with the Court of Appeals that the dispensing of drugs " 'in the course of treatment in the hospital is the hospitals' [*sic*] own use,' " regardless of whether the patient is technically described as an outpatient or as an inpatient. It does not matter, the respondent says, "whether the patient is occupying a bed or not"; thus, a "day surgery patient receiving medication while being treated in the hospital would be covered [that is, the sale to him would be exempt] whether in bed or not, as would one receiving a shot or pill while standing upright or otherwise in the outpatient clinic." Brief for Respondent 11. See also Tr. of Oral Arg. 29.

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[7] The record seemingly contains no reference to a dispensation to a special duty nurse, chaplain, or similar nonemployee professional, on duty at the hospital. We place any dispensation of this type in the same category as one to the hospital's employee or student.

[8] This division into 10 categories may not be exhaustive. It appears to cover, however, the several types of dispensations indicated by the record.

This concession, then, covers the above-listed categories 1, 2, and 3. We hasten to add, however, that if the respondent had made no concession as to these three categories, we would have reached the same result, for it seems to us to be very clear that a hospital's purchase of pharmaceutical products that are dispensed to and consumed by a patient on the hospital premises, whether that patient is bedded, or is seen in the emergency facility, or is only an outpatient, is a purchase of supplies for the hospital's "own use," within § 13c. In our view, as the respondent's concession indicates, this is so clear that it needs no further explication.

Before we turn to the remaining categories, we should state that we recognize, as the parties do, that the concept of the nonprofit hospital and its appropriate and necessary activity has vastly changed and developed since the enactment of the Nonprofit Institutions Act in 1938. The intervening decades have seen the hospital assume a larger community character. Some hospitals, indeed, truly have become centers for the "delivery" of health care. The nonprofit hospital no longer is a receiving facility only for the bedridden, the surgical patient, and the critical emergency. It has become a place where the community is readily inclined to turn, and—because of increasing costs, physician specialization, shortage of general practitioners, and other factors—is often compelled to turn, whenever a medical problem of import presents itself. The emergency room has become a facility for all who need it and it no longer is restricted to cases previously authorized by members of the staff. And patients that not long ago required bed care are often now treated on an ambulatory and outpatient basis. See *Eastern Kentucky Welfare Rights Organization* v. *Simon*, 165 U.S. App. D. C. 239, 249, 506 F. 2d 1278, 1288 (1974), cert. granted, 421 U.S. 975 (1975); Brodie & Graber, Institutional Pharmacy Practice in the 1970's, 28 Am. J. Hosp. Pharm. 240, 241 (1971).

IV

It has been said, of course, that the antitrust laws, and Robinson-Patman in particular, are to be construed liberally, and that the exceptions from their application are to be construed strictly. *United States* v. *McKesson & Robbins*, 351 U.S. 305, 316 (1956); *FMC* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973); *Perkins* v. *Standard Oil Co.*, 395 U.S. 642, 646-647 (1969). The Court has recognized, also, that Robinson-Patman "was enacted in 1936 to curb and prohibit all devices by which large buyers gained discriminatory preferences over smaller ones by virtue of their greater purchasing power." *FTC* v. *Broch & Co.*, 363 U.S. 166, 168 (1960); *FTC* v. *Fred Meyer, Inc.*, 390 U.S. 341, 349 (1968). Because the Act is remedial, it is to be construed broadly to effectuate its purposes. See *Tcherepnin* v. *Knight*, 389 U.S. 332, 336 (1967); *Peyton* v. *Rowe*, 391 U.S. 54, 65 (1968). Implied antitrust immunity is not favored. *United States* v. *National Assn. Securities Dealers*, 422 U.S. 694, 719 (1975). "[O]ur cases have repeatedly established that there is a heavy presumption against implicit [antitrust] exemptions." *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 787 (1975); *United States* v. *Philadelphia Nat. Bank*, 374 U.S. 321, 350-351 (1963). And the focus of Robinson-Patman is on competition "at the same functional level." *FTC* v. *Sun Oil Co.*, 371 U.S. 505, 520 (1963).

But the legislative history of the Nonprofit Institutions Act indicates clearly that that Act was concerned with the suspicion that Robinson-Patman, at the time just recently enacted, actually might operate to outlaw price favors that sellers would wish to grant to eleemosynary institutions. S. Rep. No. 1769, 75th Cong., 3d Sess., 1 (1938); H.R. Rep. No. 2161, 75th Cong., 3d Sess., 1 (1938). The parties here seek to utilize this legislative history in opposite ways. The respondent asserts that the statutory assurance of exemption "was never intended

to countenance a mass invasion of the retail drug sale market by hospitals," Brief for Respondent 34, and that what Congress had in mind was "the role traditionally occupied by hospitals," *id.*, at 35. The petitioners assert that the 1938 statute "was written to assist a wide range of nonprofit institutions to operate at the lowest possible cost in the public interest," Brief for Petitioners 17, and that the focus was on the character of the institution, not on the particular features of its program, and not only on those institutions that operated at a loss, *id.*, at 17-18.

We are not fully persuaded by either view. The modern American hospital developed from an institution originally intended for the sick poor. See *Eastern Kentucky Welfare Rights Organization* v. *Simon*, 165 U.S. App. D. C., at 249, 506, F. 2d, at 1288; E. Fisch, D. Freed, & E. Schachter, Charities and Charitable Foundations § 322 (1974); Bromberg, The Charitable Hospital, 20 Cath. U. L. Rev. 237, 238-240 (1970). Language in the bill which became the 1938 Act, that would have exempted only sales to nonprofit institutions "supported in whole or in part by public subscriptions," was deleted, 83 Cong. Rec. 6065 (1938), and the Act's exemption provision was not so restricted and confined. We thus do not relate the exemption to what might be described as the nonprofit hospital's original or "traditional" status. On the other hand, there is nothing in the Act that indicates that its exemption provision is to be applied and expanded automatically to whatever new venture the nonprofit hospital finds attractive in these changing days. The Congress surely did not intend to give the hospital a blank check. Had it so intended, it would not have qualified purchases by nonprofit institutions in the way it did in § 13c. See H.R. Rep. No. 1983, 90th Cong., 2d Sess., 78-79 (1968). We are concerned, after all, with an exemption from an antitrust statute, and the accepted general principles, hereinabove set forth, do have application even in the nonprofit hospital context.

We therefore conclude that the exemption provision of the Nonprofit Institutions Act is a limited one; that just because it is a nonprofit hospital that is purchasing pharmaceutical products does not mean that all its purchases are exempt from Robinson-Patman; that the test is the obvious one inherent in the language of the statute, namely, "purchases of their supplies for their own use"; and that "their own use" is what reasonably may be regarded as use *by the hospital* in the sense that such use is a part of and promotes the hospital's intended institutional operation in the care of persons who are its patients. This implies the limitation and it turns the measure naturally from the purchase to the use, as § 13c requires. In this focus we consider the several categories listed above.

V

1, 2, and 3. As to these three categories, we reiterate our conclusions already enunciated in the light of the concession by the respondent. Dispensation to the bed-occuping inpatient and to the patient at the hospital's emergency facility, in either case for use on the hospital premises, is a part of the institution's basic function, and is dispensation for the hospital's "own use." That it is the patient rather than the hospital that consumes is not determinative, and, indeed, the respondent here does not contend otherwise. A like result follows with respect to dispensation to the hospital's outpatient when that patient uses the pharmaceutical product on the hospital's premises.

4 and 5. The take-home prescription, usually a continuance of, or supplement to, what has been prescriptively administered at the hospital while the recipient was an inpatient, emergency facility patient, or outpatient, takes us, to be sure, one small step beyond and outside the hospital's door. The patient is released from care to continue his treatment and recuperation under something less than the hospital's emergency or routine

intensive, regular, or even, more casual care (if it offers that type), and less than its consultative service at its outpatient facility. The release from the hospital environment into the home is the next step in the chain of treatment on the patient's way to his resumption of normal activity completely free of treatment. The medical supervision and the hospital's participation in it to this point, at least, although approaching an end, are continuous and real, and are distinct parts of the transition from hospital care to home care. We therefore conclude that the genuine take-home prescription, intended, for a limited and reasonable time, as a continuation of, or supplement to, the treatment that was administered at the hospital to the patient who needed, and now continues to need, that treatment, is for the hospital's "own use." We therefore disagree with the Court of Appeals as to categories 4 and 5. We feel that a contrary ruling on our part would unduly and undeservedly emphasize the doorsill of the hospital, and that to draw a line at that threshold would be arbitrary and not consistent with congressional intent. In these instances, the hospital's "own use" of the pharmaceutical products extends realistically and not inappropriately somewhat beyond that threshold.

6. We conclude, however, that the refill for the hospital's former patient is on the other side of the line that divides that which is in the hospital's "own use" from that which is not. Inevitably, in accord with the test above set forth, there comes a point where the dispensation of pharmaceutical products is not for the institution's "own use." That point, we feel, is positioned short of the refill. Continuation of a drug's use for some time after initial prescription at the hospital may well be indicated for the particular patient, but, except for the limited take-home prescription referred to above, it is not the hospital's "own use," and it certainly is not for its "own use" forever just because it originated under hospital auspices. We conclude that the statute's limitation

has been exceeded when the connection with the hospital has become as attenuated as it is at the refill stage.

7. Dispensation to the hospital's employee or to its student for the purchaser's personal use or for the use of his dependent poses a somewhat different problem. A hospital is an organization populated by persons rendering essential services of various kinds. The hospital's employees enable it to function. The hospital pharmacy is but a part of the whole; the employee and his services are other parts. And to the extent the institution has students on the medical and hospital scene—interns, persons in the hospital's nursing, practical nursing, and nurse's aide programs, those in paramedical, chaplaincy, and administrative fields, and the like—the connection with the hospital's purposes and its activities is obvious and institutionally intimate. We conclude, therefore, that dispensation by the pharmacy to the hospital's employee or student, each of whom, literally, is a member of the hospital family, for his own use or for the use of his dependent, enhances the hospital function and qualifies as being in the hospital's "own use," within the meaning of § 13c.[9] But we draw the line between dispensation for the employee's or the student's personal use, or for the use of his dependent, on the one hand, and that for the use of another, even a nondependent family member, on the other.

8 and 9. What we have said in the preceding paragraph applies with equal force to dispensation to a physician member of the staff for his personal use or for the personal use of his dependent. The physician staff member, though not an employee in the technical sense of being full time in the hospital's service and on its payroll, nevertheless is vital to its existence. It is he who supplies the patient and who engages, perhaps directly and at least

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[9] The fact that, with respect to employees, the availability of the hospital pharmacy might be the compelled subject of a collective-bargaining agreement, in our view, cannot be controlling.

to some extent through the staff organization, in the formulation of the hospital's professional and operative policies. His activity at the hospital is in the hospital's use—its very purpose for existence—and dispensation to the physician and his dependent, we think, is for the hospital's "own use," within § 13c.

We again draw the line, however, when the physician's acquisition from the hospital pharmacy is not for his personal use or that of his dependent, or is not for the hospital. To the extent that the physician utilizes his proximity to the hospital pharmacy, and it permits him so to do, for other persons or other uses—even, as this record occasionally intimates, for dispensation in that portion of his private practice unconnected with the hospital—the requirement of the hospital's "own use" is not fulfilled. Here again the relationship is too attenuated for the statutory benefit, and we hold that § 13c definitely is not satisfied.

10. The walk-in prescription buyer for the most part affords little difficulty for us in the context of § 13c. Even though one acknowledges the full weight of the argument that the modern hospital is a different institution from what it was when the Nonprofit Institutions Act was adopted in 1938, and that increasingly it has become a focus of health care in the community, the extension of § 13c to the walk-in customer, who has no present connection with the hospital and its pharmacy other than as a place to have his prescription filled, would make the commercially advantaged hospital pharmacy just another community drug store open to all comers for prescription services and devastatingly positioned with respect to competing commercial pharmacies. This would extend the hospital's "own use" concept beyond that contemplated by Congress in § 13c.

We therefore hold that the walk-in buyer generally is not within the statute's exemption. We recognize, however, that there may be an occasion when the hospital

pharmacy is the only one available in the community to meet a particular emergency situation. The respondent seeks to counter this possibility with a telephone book yellow-page reference to the providing of 24-hour service, and of some emergency or delivery service, by certain metropolitan Portland retail pharmacies. Brief for Respondent 56. That may be. We are content, however, to conclude that the occasional emergency is *de minimis*, in any event, and that its presence solitarily would not trigger litigation of the present kind. So long as the hospital pharmacy holds the emergency situation within bounds, and entertains it only as a humanitarian gesture, we shall not condemn the hospital and its suppliers to a Robinson-Patman violation because of the presence of the occasional walk-in dispensation of that type.[10]

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[10] We referred above, in n. 4, to *Logan Lanes, Inc.* v. *Brunswick Corp.* The parties, in their respective ways, seek to make as much as possible of that decision. *Logan Lanes* was a treble-damages suit centering in the sale by Brunswick, to a Utah State Board, of bowling lanes and related equipment at prices lower than Brunswick charged Logan for similar equipment. The items purchased by the board were installed in a state university's student union building, and, while they were "primarily for the use of students, faculty and staff of the University," were also used by members of the public, 378 F.2d, at 214. The public use during the 20 months following installation, according to affidavits presented by Brunswick, amounted to 2,934 lines bowled out of a total of 128,349. The trial court granted Brunswick's motion for summary judgment. One ground for this ruling was that the purchase was exempt under § 13c. The Ninth Circuit affirmed. It refused to restrict the statute's use of the term "supplies" to consumables and noncapital items and, instead, held that the term embraced anything required to meet the qualified institution's needs. It concluded that the exact amount of public use was immaterial and that, even assuming "the public made substantial use of the University bowling facilities," 378 F. 2d, at 217, the purchases in question were made by the nonprofit university for its own use. The situation presented by *Students Book Co.* v. *Washington Law Book Co.*, 98 U.S. App. D.C. 49, 232 F. 2d 49 (1955), cert. denied, 350 U.S. 988 (1956), also cited by the parties here, was distinguished.

The latter case concerned sales of lawbooks to self-sustaining campus bookstores for resale at a profit. The Court of Appeals

VI

The petitioners suggest that a decision holding some dispensations by the nonprofit hospital not to be exempt establishes an objectionable and unworkable standard for hospitals and their suppliers because it "requires a segregation of drugs or accounting of their use that can be achieved only through the institution of clumsy and expensive dual supply or tracing systems to regulate and account for the use of drugs." Brief for Petitioners 28. They suggest the undesirability of a supplier's "controlling the disposition of merchandise in the hands of a purchaser," citing *United States* v. *Arnold, Schwinn & Co.*, 388 U.S. 365, 379 (1967), and they speak of the supplier's "retroactive exposure to claims." Brief for Petitioners 29.

Petitioners' concern is understandable, but we feel that it is overstated. Looking at the problem from the point of view of the purchasing hospital, two alterna-

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held, 98 U.S. App. D.C., at 50-51, n. 5, 232 F. 2d, at 50-51, n. 5, that these were not sales to universities "for their own use," within the meaning of § 13c. The defendant, however, prevailed on another ground.

We agree with the court in the *Students Book Co.* case that the purchases challenged there were not purchases by a nonprofit institution of the type to which § 13c relates. Those in *Logan Lanes*, in contrast, were. The Ninth Circuit apparently would distinguish *Logan Lanes* from the present case on the ground that "[p]lant equipment acquired for a university's own use cannot be segregated from that acquired for use by others, since the same equipment serves both uses." 510 F. 2d, at 490. It went on to say that the situation "of supplies acquired for consumption . . . is otherwise." *Ibid.* The court regarded the present case as factually similar to *Students Book Co.* As we have just stated, however, we are in accord with the District of Columbia Circuit's characterization of the bookstore purchases as not being transactions with the universities at all, but with the campus bookstores for resale at the latter's profit.

tives, and perhaps more,[11] are presented. The first, and easier, is for the hospital pharmacy *not* to dispense in any way hereinabove held to be outside the exemption of § 13c. The second is for the pharmacy to do exactly what the petitioners deplore, namely to establish a recordkeeping procedure that segregates the nonexempt use from the exempt use. This would be supplemented by the hospital's submission to its supplier of an appropriate accounting followed by the price adjustment that is indicated. This, to be sure, is cumbersome, but it obviously is the price the Congress has exacted for the benefits bestowed by the controlling legislation, and it should be no more cumbersome than the accounting demands that are made on commercial enterprises of all kinds in our complex society of today.

The supplier, on the other hand, properly may expect to be protected from antitrust liability for reasonable and noncollusive reliance upon its hospital customer's certification as to its dispensation of the products it purchases from the supplier. But it is not unreasonable to expect the supplier to assume the burden of obtaining the certification when it seeks to enjoy, with the institutional purchaser, the benefits provided by § 13c. It clearly does this with respect to responsibility for identification of its purchaser under that statute's standard, and little additional burden is imposed if it is required to take the small second step of routinely obtaining a representation from its hospital customer as to the use of the products purchased.

The judgment of the Court of Appeals is vacated, and the case is remanded for further proceedings consistent with this opinion. Costs are allowed to petitioners to the extent of 50%.

It is so ordered.

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[11] Our reference to two alternatives is not meant to be exclusive. Imaginative suppliers and purchasers may well come up with other and better means to alleviate whatever routine recordkeeping details and burdens may exist.

MR. JUSTICE STEVENS took no part in the consideration or decision of this case.

MR. JUSTICE MARSHALL, concurring.

While I join the Court's opinion, I wish to add a word about the applicability of the exemption provided by the Nonprofit Institutions Act. To my mind, the key to the Act is that it exempts from the Robinson-Patman Act not only an itemized list of institutions, but also all "charitable institutions not operated for profit." 15 U.S.C. § 13c. This suggests to me that the named institutions—schools, colleges, universities, public libraries, churches, and hospitals—were not intended to be limited to their traditional activities in qualifying for the exemption, but may expand those activities and still qualify so long as any new activities for which exempted supplies are purchased are charitable and not operated for profit.

I agree with the Court that the exemption is not "to be applied and expanded automatically to whatever new venture the nonprofit hospital finds attractive in these changing days." *Ante*, at 13. But I believe the exemption *is* applicable to any new venture the hospital finds attractive and that is both charitable and not operated for profit. There is no suggestion—nor could one be made—that the activities the Court today finds outside the exemption fall within this category,* so there is no need to address this problem here. But I write to emphasize that I do not read the Court's opinion as foreclosing hospitals—or other exempted institutions—from expanding their charitable activities in highly untraditional ways and still qualifying for the exemption.

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* This case would be much more difficult for me if the hospitals involved did not all make profits on the sale of drugs to outsiders. *Ante*, at 7. If they did not, we would have to determine in each case whether such sales, even if not within the hospital's institutional function, nonetheless constituted a "charitable" venture of their own.

Likewise, I agree with the Court that the proper inquiry in this case is whether each kind of drug sale by the hospital "is a part of and promotes the hospital's intended institutional operation in the care of persons who are its patients." *Ante*, at 14. However, when a nonprofit institution makes sales for profit, as here, analysis is furthered. I suggest, by recognition of the purpose of the "own use" limitation.

Since all charitable institutions are covered by the Act, the purpose quite obviously is not to freeze a particular charitable institution into a particular kind of charity. Rather, as I understand it, the purpose of the limitation is generally to preclude the institution from taking advantage of its antitrust exemption by buying low-cost supplies solely for the purpose of reselling them at a profit. That is, Congress was primarily interested in directly aiding nonprofit institutions by lowering their operating expenses, but not interested in indirectly aiding such institutions by providing them with the means of raising additional money—particularly when such resales of supplies would put the institution in competition with retail businesses not eligible for the exemption. While I do not believe Congress meant to preclude profit-making sales in the course of the institution's charitable activities—and so I agree that the Court's inquiry is the correct one—I suggest that the nexus between particular sales and those activities should be particularly closely scrutinized when a profit is made to assure that the sales are not made primarily for moneymaking purposes. Thus, sales only arguably within the scope of the institution's charitable activities might be exempted when made on a nonprofit basis and not exempted when made for profit. After analysis with this balancing factor in mind, I agree with the lines drawn by the Court and concur in its opinion.

MR. JUSTICE STEWART, with whom MR. JUSTICE BRENNAN joins, dissenting.

It is common ground in this case that the dispensation of pharmaceutical products for consumption by a hospital's patients upon the hospital's premises constitutes the hospital's "own use" of the products within the meaning of 15 U.S.C. § 13c. The controversy concerns the various other "uses" of these products catalogued in the Court's opinion. *Ante*, at 8-10. As to those uses the Court of Appeals expressed its views as follows:

> "We may concede that in these respects distribution by the hospitals can be justified as a proper and useful community service and thus can be regarded as a proper hospital function. It is not, however, the hospitals' 'own use.' . . . The purpose for which these supplies are purchased—the use to which they are to be put—is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer.
>
> "The hospitals here are (quite properly) accommodating patients, staff and strangers with means whereby they can conveniently purchase for *their* use. The question is not whether the hospitals can continue to provide this useful community service. The question is whether in providing it they may acquire the drugs for such resale at an acquisition price that discriminates against local retail druggists. We hold that they may not." 510 F. 2d 486, 489.

I agree with the Court of Appeals and would affirm its judgment.

84-1038

DEC 28 1984

ALEXANDER L. STEVAS
CLERK

In the Supreme Court

of the United States

OCTOBER TERM, 1984

NO.

MARIO DE MODENA, dba SIXTH AVENUE PHARMACY, *et. al.*,
Petitioners

-V.-

KAISER FOUNDATION HEALTH PLAN, INC., *et. al.*, *Respondents.*

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.
Petitioner,

-V.-

KAISER FOUNDATION HEALTH PLAN, INC., *et. al.*, *Respondents.*

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF FOR ALABAMA PHARMACEUTICAL ASSOCIATION FLORIDA PHARMACY ASSOCIATION GEORGIA PHARMACEUTICAL ASSOCIATION KENTUCKY PHARMACISTS ASSOCIATION LOUISIANA PHARMACISTS ASSOCIATION MARYLAND PHARMACEUTICAL ASSOCIATION MISSISSIPPI STATE PHARMACEUTICAL ASSOCIATION AND VIRGINIA PHARMACEUTICAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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In the Supreme Court

of the United States

OCTOBER TERM, 1984

NO.

MARIO DE MODENA, dba SIXTH AVENUE PHARMACY, *et. al.*,

Petitioners

-V.-

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MOTION OF THE ALABAMA PHARMACEUTICAL ASSOCIATION FLORIDA PHARMACY ASSOCIATION, GEORGIA PHARMACEUTICAL ASSOCIATION, KENTUCKY PHARMACISTS ASSOCIATION, LOUISIANA PHARMACISTS ASSOCIATION, MARYLAND PHARMACEUTICAL ASSOCIATION, MISSISSIPPI STATE PHARMACEUTICAL ASSOCIATION, AND VIRGINIA PHARMACEUTICAL ASSOCIATION, AS *AMICUS CURIAE* IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

The brief urges the Court to issue a writ of certiorari to review the opinion of the decision of the Court of Appeals for the Ninth Circuit in the above entitled case.

Counsel for the Petitioners has consented to the filing of the attached brief. Counsel for the Respondents have not consented to its filing.

The Interest of the Pharmaceutical Associations of Alabama, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, and Virginia

The Pharmaceutical Associations of Alabama, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, and Virginia (referred to hereafter as "the associations") are the professional organizations representing the individual pharmacists in these respective eight states. The general purposes of these eight professional pharmaceutical associations are to promote the public welfare through the profession of pharmacy and to represent the interest of the individual pharmacists within these eight states.

It is in the furtherance of the above-stated purposes that these eight state pharmaceutical associations wish to express to this Court their views as to the significance of the decision of the Court of Appeals for the Ninth Circuit in this matter and to urge the issue of a writ of certiorari to review the opinion.

The decision of the Court of Appeals has massive precedential consequences to retail pharmacy in all eight of the above-mentioned states. The decision of the Court of Appeals threatens the existence of community retail pharmacy in all eight states.

The associations contend that the holding of the Court of Appeals in this case is not consistent with the legislative intent of the Nonprofit Institutions

Act and the Robinson-Patman Act. The construction of the Nonprofit Institutions Act exemption in the Ninth Circuit Court of Appeals' opinion would result in a circumvention of the purpose of both this statute and the Robinson-Patman Act, thus creating potential for a monopolistic climate which could destroy community retail pharmacy.

The Nonprofit Institutions Act was enacted to confer benefits upon nonprofit institutions in limited areas where the nonprofit institution operates on a different functional level than private enterprise.

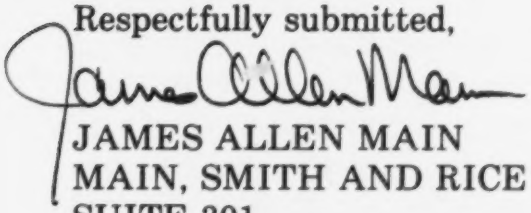
The ultimate result of a decision allowing Health Maintenance Organizations to compete on the same functional level as retail pharmacy without the restrictions of the Robinson-Patman Act of 1936 would destroy the retail pharmacy segment of local business. It would destroy retail pharmacy because it would allow and encourage Health Maintenance Organizations to resell pharmaceuticals to the general public in competition with retail pharmacy at a price below the acquisition cost of retail pharmacies. The simple economics of such a business climate would result in the closing of retail pharmacies and the monopolizing of pharmacy by Health Maintenance Organizations. Such a result would adversely affect the delivery of health care services at the community level.

In view of the tremendous impact on pharmacy in these eight states that the Ninth Circuit Court of Appeals decision would have, surely it is appropriate that the pharmacists of these eight states be given the opportunity to convey to the Court their view of the application of this exemption to the Robinson-Patman Act as it affects their profession.

Accordingly, the Alabama, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, and Virginia

Pharmaceutical Associations respectfully urge this Court to grant their motion for leave to file this brief as *amicus curiae.*

Respectfully submitted,



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AND
VIRGINIA PHARMACEUTICAL ASSOCIATION,
AS *AMICUS CURIAE* IN SUPPORT OF
PETITION FOR
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Interest of *Amicus Curiae*

The interest of Alabama Pharmaceutical Association, Florida Pharmacy Association, Georgia Pharmaceutical Association, Kentucky Pharmacists Association, Louisiana Pharmacists Association, Maryland Pharmaceutical Association, Mississippi State Pharmaceutical Association, and Virginia Pharmaceutical Association as *amicus curiae* is set forth in the preceding motion for leave to file this brief.

Question Presented

Is the Nonprofit Institutions Act exemption to the Robinson-Patman Act of 1936 applicable to the purchase of pharmaceuticals by a Health Maintenance Organization (HMO) for resale in competition with retail pharmacies?

Statutes Involved

1. Section 1 of the Robinson-Patman Act, 49 Stat. 1526, 15 U.S.C. § 13 (a):

> "(a) It shall be unlawful for any person engaged in commerce, in the course of such commerce, either directly or indirectly to discriminate in price between different purchasers of commodities of like grade and quality, where either or any of the purchases involved in such discrimination are in commerce, where such commodities are sold for use, consumption, or resale within the United States or any Territory thereof or the District of Columbia or any insular possession or other place under the jurisdiction of the United States, and where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competi-

tion with any person who either grants or knowingly receives the benefit of such discrimination, or with customers of either of them. . . ."

2. The Nonprofit Institutions Act, 52 Stat. 446, 15 U.S.C. § 13c:

"Nothing in sections 13 to 13b and 21a of this title, shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit."

Statement Of The Case

1. Proceedings in the Lower Courts

Petitioners filed these antitrust actions charging Respondents with violations of three distinct antitrust provisions: (1) Section 2(f) of the Robinson-Patman Anti-Price Discrimination Act, 15 U.S.C. § 13 *et. seq.* (1970), by knowingly inducing or receiving discriminatory low prices from pharmaceutical suppliers; (2) Section 2 of the Sherman Act. 15 U.S.C. § 2, by attempting to monopolize the retail drug market; and (3) Section 1 of the Sherman Act, by unlawfully tying health products and services for sale. The Petitioners actions were consolidated for trial.

Respondents filed a motion for summary judgment on the Petitioners claims and on February 17, 1983 the district court granted the motion on all three claims.

The Court of Appeals for the Ninth Circuit affirmed the district court with respect to the claim of attempted monopolization, the tie-in claim and the conclusion that drug purchases made by Respondents for resale to its members are exempt from the Robinson-Patman Act under the exception created by the Nonprofit In-

situtions Act 15 U.S.C. § 13c (1970). The Court of Appeals reversed the district court's determination that Respondents' sales of drugs to non-members constituted a de minimus violation of the Robinson-Patman Act (743 F 2d 1388). Petitioners filed Motions for Reconsideration, and to Alter or Amend Judgment which were denied March 3, 1983 and March 16, 1983.

2. Court of Appeals Decision

The Court of Appeals concluded that a non-profit Health Maintenance Organization is a charitable institution and that ALL drug purchases made by the HMO for resale to its members or subscribers is qualified for protection under the Nonprofit Institutions Act. In holding that a HMO is qualified for protection under the Nonprofit Institution Act the Ninth Circuit reasoned that a liberal interpretation of the term "charitable institution" in the Nonprofit Institutions Act is applicable to HMO's and after analysis of the function of the HMO summarized its view as:

> "Given this extraordinarily broad INSTITUTIONAL FUNCTION, any sale of drugs by an HMO to one of its members falls within the basic function of the HMO. Consequently, we must conclude that drugs purchased by an HMO, such as Kaiser-Permanente, for resale to its members are purchased for the HMO's 'own use' within the meaning of the Nonprofit Institutions Act and thus qualify for protection under the Act."[1] (emphasis added)

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1. *De Modena v. Kaiser Foundation Health Plan, Inc.*, 743 F. 2d 1388 (9th Circuit 1984)

Summary of Argument

In 1936 Congress enacted the Robinson-Patman Act to protect small business against discriminatory price practices of large interstate businesses.[2] Two years later the Nonprofit Institutions Act of 1938 was enacted as an exemption from the Robinson-Patman Act for certain nonprofit institutions in the purchase of supplies for their own use.

The issue in this case is whether or not Health Maintenance Organizations (HMOs) may invoke the Nonprofit Institutions Act exemption to purchase pharmaceuticals "for resale" to subscribers to the HMO's Supplemental Health Care Plan without violating the legislative mandate of the Robinson-Patman Act.

The Robinson-Patman Act of 1936 was enacted to assure that businesses operating on a competitive functional level would be on an equal basis as far as price is concerned.[3] Congress intended to eliminate price discrimination practices threatening small independent merchants.

The Nonprofit Institutions Act of 1938 was enacted to allow certain nonprofit institutions to acquire their supplies as inexpensively as possible. This exemption was intended for the purchase of "supplies" for the institutions' own use, not the purchase of commodities for resale.

In 1976, this Court, in a factually similar case, *Abbott Labs vs. Portland Retail Druggist Association,*[4] recognized that "the focus of Robinson-Patman is

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2. *Federal Trade Commission v. Anheuser-Busch, Inc.,* 363 U.S. 536 (1960)
3. *Federal Trade Commission v. Sun Oil Company,* 371 U.S. 505 (1963)
4. 425 U.S. 1,13 (1976)

competition at the same functional level". In applying the Nonprofit Institutions Act exemption to HMO's, without regard to functional levels of competition, the Ninth Circuit Court of Appeals has given HMO's a "blank check" in the resale of pharmaceuticals acquired with the advantage of discriminatory prices. The decision is in direct conflict with the acknowledged focus and intent of Robinson-Patman.

HMO's are legal entities designed by Congress in 1973 to increase the options from the point of view of the consumer. The legislative purpose was not to "remake" the health care delivery system but to improve the opportunities of the general public to obtain quality health care.[5]

The Ninth Circuits' holding would "remake" the health care delivery system by allowing the advantage of discriminatory prices by HMO's to destroy private enterprise, i.e., competing commercial pharmacies.

HMO's engaging in the sale of pharmaceuticals to ambulatory patients as subscribers to their Supplemental Health Care Plan are on the same functional level as retail pharmacy. When any entity chooses to operate on the same functional level as retail pharmacies, they are not entitled to purchase these "supplies" for resale under the Nonprofit Institutions Act exemption to the Robinson-Patman Act.

The Ninth Circuit has ignored the functional level test implicit in the categorical rules established in *Abbott Labs.* In its attempt to analogize the HMO as a Nonprofit Institutions Act entity the Ninth Circuit has created definitions of the terms "charitable" and

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5. 1973 U.S. Code Cong. and Adm. News, p. 3039

"own use" that circumvent the purpose of the Nonprofit Institutions Act.

The importance and substantiality of the question presented has massive precedential consequences to retail pharmacy.

For these reasons, a writ of certiorari should issue to review the opinion of the Ninth Circuit.

ARGUMENT

Introduction

The Robinson-Patman Antidiscrimination Act was enacted by Congress in 1936 to protect small businesses against favoritism shown by suppliers to large buyers.[6] It provides in part that:

> "It shall be unlawful for any person engaged in commerce, in the course of such commerce, either directly or indirectly, to discriminate in price between different purchasers of commodities of like grade and quality, . . . where such commodities are sold for use, consumption, or resale within the United States . . . , and where the effect of such discrimination may be substantially to lessen competition. . . ."[7]

Two years later, in 1938, the Nonprofit Institutions Act was enacted as an exemption from the prohibitions of the Robinson-Patman Act for nonprofit institutions in the purchase of supplies for their own use. The Nonprofit Institutions Act provides:

> "Nothing in sections 13 to 13b and 21a of this title, shall apply to purchases of their supplies for

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6. *Federal Trade Commission v. Anheuser-Busch, Inc.*, 363 U.S. 536 (1960); *Federal Trade Commission v. Sun Oil Company*, 371 U.S. 505 (1963)

7. Section 1 of the Robinson-Patman Act, 49 Stat. 1526, 15 U.S.C. § 13(a)

> their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit."[8]

The instant question *Amicus Curiae* seeks this Court to address is whether or not the Nonprofit Institutions Act can be used to circumvent the purpose of the Robinson-Patman Act by allowing Health Maintenance Organizations to invoke this exemption to purchase pharmaceuticals "for resale" to the subscribers to their Supplemental Health Services Plan. This particular circumvention of the purpose of the Robinson-Patman Act would threaten the survival of smaller local merchants (retail pharmacy), the protection of which is the very purpose of the Robinson-Patman Act.

Congress established Health Maintenance Organizations in 1973 as legal entities that may enter into contractural relationships with "members" as "subscribers" for health services.[9]

An HMO is required to provide basic health services and is allowed to contract with subscribers for supplemental health services (including pharmaceuticals). The individual subscriber has the option to contract or not to contract for the supplemental health services, based on comparison in the market place.

The Ninth Circuit's holding would exempt HMO's from the Robinson-Patman Act and therefore from the competitive force of the market place.

The focus and rationale of the Robinson-Patman Act demands preservation of community pharmacies and community pharmacy as a competitive force in

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8. The Nonprofit Institutions Act, 52 Stat. 446, 15 U.S.C. § 13c.
9. Health Maintenance Organization Act, 42 U.S.C. §§ 300e, *et. seq.* (1973)

the market place. The Court of Appeals decision would destroy commercial pharmacies as a competitive force in the market place.

I.

THE NINTH CIRCUIT COURT OF APPEALS DECISION IS IN DIRECT CONFLICT WITH THIS COURTS DECISIONS STATING THE ACKNOWLEDGED FOCUS AND INTENT OF THE ROBINSON-PATMAN ACT OF 1936.

The Robinson-Patman Act was enacted to assure that businesses at the same functional level would start on an equal competitive footing as far as price is concerned.[10]

The Robinson-Patman Act was enacted as a protection for small businesses which are unable to buy in quantities against competing operations of large interstate concerns.[11] Price favoritism shown by suppliers to large buyers caused congressional concern for the survival of small local merchants, and the 1936 Robinson-Patman amendments to the Clayton Act were passed to strengthen the Clayton Act prohibitions on price discrimination.[12] Thus the fundamental purpose of the Robinson-Patman Act is to protect the small independent businessman.

This Court's opinion explaining the basic purposes of the Robinson-Patman Act in *Federal Trade Com-*

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10. *Federal Trade Commission v. Sun Oil Company,* 371 U.S. 505 (1963).

11. *Federal Trade Commission v. Morton Salt Co.,* 334 U.S. 37 (1948); *Standard Oil Co. v. Federal Trade Commission,* 340 U.S. 231 (1951).

12. *Federal Trade Commission v. Anheuser Busch, Inc.,* 363 U. S. 536 (1960); *Federal Trade Commission v. Sun Oil Company,* 371 U.S. 505 (1963).

mission v. Sun Oil[13] expounds the position of retail pharmacy in this case. The Court stated that the basic purpose of the Act was to insure that purchasers from a single supplier would not be injured by that supplier's discriminatory practices. The Court noted that "Congress sought generally to obviate price discrimination practices threatening independent merchants and businessmen presumably from whatever source."[14] It is irrefutable that retail pharmacies are members of that class of independent merchants and businessmen which the Robinson-Patman Act protects.

The question then must focus on the level of protection Congress intended for independent merchants and businessmen. *Federal Trade Commission v. Sun Oil Co.*, answers this query in the following language:

> "In short, Congress intended to assure, to the extent reasonably practicable, that businessmen at the SAME FUNCTIONAL LEVEL would start on equal competitive footing so far as price is concerned."[15] (emphasis added)

This Court in *Abbott Labs v. Portland Retail Druggist Association*[16] rejected the appliciation of the Non-profit Institutions Act exemption to the Robinson-Patman Act for non-profit hospitals engaged in the "resale" of pharmaceuticals at the same functional level as commercial pharmacies. The categorical rules established in *Abbott Labs* clearly apply the com-

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13. 371 U.S. 505 (1963).
14. IBID., 520
15. IBID.
16. 425 U.S. 1 (1976).

petitive functional level focus of the Robinson-Patman Act.

In applying the Nonprofit Institutions Act exemption to HMO's, without regard to functional levels of competition, the Ninth Circuit Court of Appeals has given HMO's a "blank check" in the resale of pharmaceuticals acquired with the advantage of discriminatory prices. The Appeals Court decision is in direct conflict with the acknowledged focus and intent of the Robinson-Patman Act and decisions of this Court such as *Abbott Labs* and *Sun Oil Co.*

HMO's are legal entities designed by Congress to increase the options from the point of view of the consumer. The legislative history clearly shows that Congress did not intend to "remake" the health care delivery system but rather to increase the market place options available to the general public in obtaining quality health care.[17]

Unquestionably, the Robinson-Patman Act should be applicable to HMO's in the purchase of pharmaceuticals for resale to the subscribers to their supplemental health care plan.

II.

THE NINTH CIRCUIT COURT OF APPEALS DECISION IS IN DIRECT CONFLICT WITH THIS COURTS DECISIONS IN THE APPLICATION OF THE NONPROFIT INSTITUTIONS ACT OF 1938.

The Nonprofit Institutions Act was enacted to allow inexpensive acquisition of supplies by nonprofit institutions for their own use-not for resale.

An examination of the statutory language used in the Nonprofit Institutions Act [18] readily reveals the

17. 1973 U.S. Code Cong. and Adm. News p. 3039

18. The Nonprofit Institutions Act, 52 Stat. 446, 15 U.S.C. § 13c.

restrictive phraseology employed by Congress to limit this exemption from the Robinson-Patman Act. It can be fairly inferred that Congress did not intend to modify or change the purpose of the Robinson-Patman Act by the Nonprofit Institutions Act from the House Judiciary Committee's comment that "(t)he Committee does not feel that the wholesome purpose of the Robinson-Patman Act will be interferred with by the enactment of this bill. . . ."[19]

In its attempt to analogize the HMO as a Nonprofit Institutions Act entity the Ninth Circuit has created liberal definitions of the terms "charitable institution" and "own use" that circumvent the purpose of the Nonprofit Institutions Act.

On the other hand the Court of Appeals decision attempts to strictly apply the categorical rules established in *Abbott Labs* to an entity (HMO) whose structure and function are vastly different from a hospital. Furthermore, the Ninth Circuit has ignored the functional level test implicit in the categorical rules established in *Abbott Labs.*

The Ninth Circuit's holding would "remake" the health care delivery system by allowing the advantage of discriminatory purchase price to HMO's to destroy competing private enterprise pharmacies.

It has consistently been adhered to by this Court that exceptions contained in statutes, such as the Robinson-Patman Act, are to be construed strictly.[20] The Ninth Circuit's construction of the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e, *impliedly* repealed the antitrust laws as to

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19. House Report 2161, 7th Cong., 3d Sess., April 1938.
20. *United States v. Scharton,* 285 U.S. 518 (1932); *Jefferson County Pharmaceutical Association, Inc. v. Abbott Laboratories, et. al.,* 460 U.S. 150 (1983).

health maintenance organizations and their affiliates. In *Moore v. Mead's Fine Bread Company, a Corp.*, Justice Douglas stated:

> "It is, we think, clear that Congress by the Clayton Act and Robinson-Patman Act barred the use of interstate business to destroy local business. . . ."[21]

The Court of Appeals decision not only allows HMOs to destroy commercial pharmacies but in fact encourages the destruction of these local businesses.

In summary, HMO's engaging in the sale of pharmaceuticals to ambulatory patients as subscribers to their Supplemental Health Care Plan are on the same functional level as retail pharmacy. The amicus position is that when any entity chooses to operate on the same functional level as private commercial enterprise, they are *not* entitled to purchase the commodity for resale under the Nonprofit Institutions Act exemption to the Robinson-Patman Act. The Ninth Circuit opinion is in conflict with the Robinson-Patman Act, the Nonprofit Institutions Act and decisions of this Court.

The importance and substantiality of the question presented has massive precedential consequences to retail pharmacy, commercial enterprises and the health care delivery system.

For these reasons, a writ of certiorari should be issued to review the opinion of the Ninth Circuit.

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21. 348 U.S. 115, 121 (1954).

CONCLUSION

For the foregoing reasons, *amicus curiae* respectfully urges that this Court grant Petitioners writ of certiorari to the Court of Appeals.

Respectfully submitted,

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BRIEF OF THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS AS AMICUS CURIAE IN SUPPORT OF PETITION

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BRIEF OF THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS AS AMICUS CURIAE IN SUPPORT OF PETITION

QUESTIONS PRESENTED

Does the Robinson-Patman Act, the Nonprofit Institutions Act, or the Health Maintenance Organization Act grant an implied exemption from the Robinson-Patman Act for purchases of drugs by health maintenance organizations for resale to their subscribers?

Are health maintenance organizations charitable institutions covered by the Nonprofit Institutions Act?

Are drugs purchased by health maintenance organizations for resale to their subscribers purchases of "supplies for their own use" under the Nonprofit Institutions Act and thereby exempt from the Robinson-Patman Act, where the health maintenance organization knowingly purchases drugs at discriminatorily low prices without any cost justification pursuant to the Nonprofit Institutions Act exemption and resells the drugs in direct competition with disfavored retail pharmacies?

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Robinson, *The HMO/PPO surge—Pharmacy tries to cope*, 128 Drug Topics 48 (June 4, 1984) 1, 13

All parties have consented to the filing of this Brief for amicus curiae in support of the petition for writ of certiorari, pursuant to Rule 36.2 of the Court.

INTEREST OF AMICUS CURIAE

Founded in 1898, the National Association of Retail Druggists (NARD) is a private, nonprofit, voluntary organization composed of approximately 20,000 independent retail pharmacists, who own approximately 30,000 independent retail pharmacies. NARD is the only national association which represents exclusively the interests of independent retail druggists. NARD has members in all fifty states, the District of Columbia, Puerto Rico, and the Virgin Islands. NARD members serve an estimated 18 million consumers daily. Independent retail pharmacists fill approximately 60% of the prescriptions filled at retail in the United States.

Members of NARD compete with each other, with chain drug stores, with for-profit and nonprofit hospital pharmacies, with fee for service physicians, and with for-profit and nonprofit health maintenance organizations (HMOs) in the sale at retail of prescription and non-prescription drugs. The decision by the Ninth Circuit exempting nonprofit HMOs from the strictures of the Robinson-Patman Act prohibiting price discrimination adversely affects NARD members because it allows nonprofit HMOs, with which NARD members increasingly find themselves in competition,[1] a favored competitive position by allowing the HMOs to knowingly obtain pharma-

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[1] In 1984 there were 342 HMOs in the United States. Two thirds of these HMOs are nonprofit. In 1983 HMOs had 15 million subscribers. *See* Operational Prepaid Health Care Plans in the United States—OHMO (October 1, 1984). Given the encouragement of this form of health care by the government it is estimated that 50 million Americans will be covered by HMOs by 1993. Robinson, *The HMO/PPO surge—Pharmacy tries to cope*, 128 Drug Topics 48 (June 4, 1984).

ceuticals at discriminatorily low, non cost justified prices. As a result NARD members have lost, and will continue to lose, retail sales, profits, and competitive position in the retail prescription and nonprescription drug markets. The applicability of the Robinson-Patman Act to purchases of pharmaceuticals for resale by nonprofit HMOs is of vital interest to retail pharmacists, and the decision of the Ninth Circuit that such purchases are beyond the reach of the Robinson-Patman Act has a direct and significant impact on NARD members.

STATUTES INVOLVED

1. Section 2 of the Robinson-Patman Act, Pub. L. No. 74-692, 49 Stat. 1526 (1976) (codified with some differences in language at 15 U.S.C. § 13(a)) (hereinafter cited as 15 U.S.C. § 13 (a)):

> That it shall be unlawful for any person engaged in commerce, in the course of such commerce, either directly or indirectly, to discriminate in price between different purchasers of commodities of like grade and quality, where either or any of the purchases involved in such discrimination are in commerce, where such commodities are sold for use, consumption, or resale within the United States or any Territory thereof or the District of Columbia or any insular possession or other place under the jurisdiction of the United States, and where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition with any person who either grants or knowingly receives the benefit of such discrimination, or with customers of either of them . . . .

2. The Nonprofit Institutions Act, Pub. L. No. 75-550, 52 Stat. 446 (1976) (codified with some differences in language at 15 U.S.C. § 13c) (hereinafter cited as 15 U.S.C. § 13c):

> . . . that, nothing in the Act approved June 19, 1936 (Public, Numbered 692, Seventy-fourth Congress, Second Session), known as the Robinson-Patman Antidiscrimination Act, shall apply to purchases of their sup-

plies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit.

3. The Health Maintenance Organization Act, Pub. L. No. 93–222, 87 Stat. 914 (1973) (codified with some differences in language at 42 U.S.C. §300e *et seq.*):

> § 300e. (a) For purposes of this subchapter, the term "health maintenance organization" means a legal entity which (1) provides basic and supplemental health services to its members in the manner prescribed by subsection (b) of this section, and (2) is organized and operated in the manner prescribed by subsection (c) of this section.
>
> (b) A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this subchapter, basic and supplemental health services to its members in the following manner:
>
> (1) Each member is to be provided basic health services for a basic health services payment . . . . A health maintenance organization may include a health service, defined as a supplemental health service by section 300e-1(2) of this title, in the basic health services provided its members for a basic health services payment described in the first sentence . . . .
>
> (2) For such payment or payments (hereinafter in this subchapter referred to as "supplemental health services payments") as the health maintenance organization may require in addition to the basic health services payment, the organization may provide to each of its members any of the health services which are included in supplemental health services (as defined in section 300e-1(2) of this title) . . . .
>
> § 300e-1. For purposes of this subchapter:
>
> (1) The term "basic health services" means—
>
> (A) physician services (including consultant and referral services by a physician);
>
> (B) inpatient and outpatient hospital services;

(C) medically necessary emergency health services;

(D) short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;

(E) medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;

(F) diagnostic laboratory and diagnostic and therapeutic radiologic services;

(G) home health services; and

(H) preventive health services (including (i) immunizations, (ii) well-child care from birth, (iii) periodic health evaluations for adults, (iv) voluntary family planning services, (v) infertility services, and (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction . . . .

(2) The term "supplemental health services" means any health service which is not included as a basic health service under paragraph (1) of this section. If a health service provided by a physician may also be provided under applicable State law by a dentist, optometrist, podiatrist, or other health care personnel, a health maintenance organization may provide such service through an optometrist, dentist, podiatrist, or other health care personnel (as the case may be) licensed to provide such service.

REASONS FOR GRANTING THE WRIT

The Case Presents Important Questions Of Federal Law Which Should Be Settled By The Court

Whether Congress in enacting an exemption from the Robinson-Patman Act for "charitable institutions" intended to exempt sales at non-cost-justified discriminatorily low prices to purchasers who resell at the same functional level is, as the Ninth Circuit noted, a question of first impression. Based on its misreading of the legislative history of the Nonprofit Institu-

tions Act and the Health Maintenance Organization Act ("HMO Act"), the Ninth Circuit has broadly expanded a narrow exemption from the antitrust laws and in so doing has misapplied the Court's decision in *Abbott Laboratories v. Portland Retail Druggists Association*, 425 U.S. 1 (1976) ("*Portland Retail Druggists*"). The Ninth Circuit's decision turns on its head Congress' intent in passing the Nonprofit Institutions Act and the HMO Act by giving an unfair competitive advantage to one of several competitive forms of retail drug distribution.

The Court should grant a writ of certiorari in this case because of the obvious need for a definitive construction of language in the Nonprofit Institutions Act and because of the need to provide a definitive statement of the relationship between the antitrust laws and the Health Maintenance Organization Act.

ARGUMENT

I. Congress Has Not Exempted HMOs From The Robinson-Patman Act

The Ninth Circuit's decision allows nonprofit HMOs to knowingly induce and receive discriminatorily low prices for drugs which the HMOs then resell to their members in competition with other retail methods of distribution. This result was based on the Ninth Circuit's interpretation of the charitable institutions exemption to the Robinson-Patman Act. The decision creates a broad exemption from the Robinson-Patman Act for the resale of drugs by HMOs to their members. This exemption has no basis in the language or legislative histories of the Robinson-Patman Act, the Nonprofit Institutions Act, or the HMO Act.

The Robinson-Patman Act makes it unlawful for one engaged in commerce to discriminate in price between different purchasers of like commodities where "the effect of such discrimination may be substantially to lessen competition." 15

U.S.C. § 13(a). The Act "was enacted in 1936 to curb and prohibit all devices by which large buyers gained discriminatory preferences over smaller ones by virtue of their greater purchasing power." *FTC v. Henry Broch & Co.*, 363 U.S. 166, 168 (1960). The Robinson-Patman Act was enacted to ensure that competition among business institutions that operate "at the same functional level" is fair. *FTC v. Sun Oil Co.*, 371 U.S. 505, 520 (1963).

In 1938, Congress enacted the Nonprofit Institutions Act, which exempts from the Robinson-Patman Act purchases by "schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit" of "supplies for their own use . . . ." 15 U.S.C. § 13c. The legislative history of the Nonprofit Institutions Act indicates that its drafters intended to ensure that the recently enacted Robinson-Patman Act did not preclude sellers from favoring eleemosynary institutions with reduced prices. S. REP. NO. 1769, 75th Cong., 3d Sess. 1 (1938); H.R. REP. NO. 2161, 75th Cong., 3d Sess. 1 (1938).

In the case most related to this one the Court stated: "The antitrust laws, and Robinson-Patman in particular, are to be construed liberally, and . . . exceptions from their application are to be construed strictly." *Abbott Laboratories v. Portland Retail Druggists Association, supra*, 425 U.S. at 11 (1976) (citations omitted). "[O]ur cases have repeatedly established that there is a heavy presumption against implicit exemptions" from the antitrust laws. *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787 (1975).

In *Portland Retail Druggists, supra*, the Court applied these antitrust law principles to limit narrowly the scope of the exemption available to nonprofit hospitals, one of the specifically enumerated institutions under the Nonprofit Institutions Act. The Court declined to grant nonprofit hospitals a blanket exemption for all pharmaceutical purchases and held that drugs purchased for uses not intrinsically connected with the

hospital's basic institutional functions (the care of its patients) were not exempt.

> [T]here is nothing in the [Nonprofit Institutions] Act that indicates that its exemption provision is to be applied and expanded automatically to whatever new venture the nonprofit hospital finds attractive in these changing days. The Congress surely did not intend to give the hospital a blank check. Had it so intended, it would not have qualified purchases by nonprofit institutions in the way it did in § 13c.

425 U.S. at 13. In particular, the Court held that prescription refills for former hospital patients, dispensations for personal use to persons other than hospital staff members and their dependents, and sales to walk-in (non-patient) purchasers were not within the exemption to the Robinson-Patman Act.

The Robinson-Patman Act by its terms does not exempt drug purchases by HMOs.[2] The only relevant express exemption is that contained in 15 U.S.C. § 13c for hospitals and other nonprofit "charitable institutions."

Congress did not exempt HMO purchases from the application of the Robinson-Patman Act when it enacted the Health Maintenance Organization Act and subsequent amendments thereto. That Act was intended to promote a *competitive* alternative for health care. It was not intended to favor with an

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[2] To the extent that a nonprofit hospital purchases drugs for use in providing health care to the members of an HMO, those purchases are exempt under the Nonprofit Institutions Act under the Court's decision in *Portland Retail Druggists, supra*, provided the pharmaceuticals are used solely for purposes intrinsic to the *hospital's* basic institutional purposes. While the Ninth Circuit's conclusion that respondents' hospitals are eligible for the Nonprofit Institutions Act exemption is, therefore, facially correct, the decision failed to restrict the exemption to the uses by the hospitals allowed under *Portland Retail Druggists*. To that extent, the Ninth Circuit's decision is in direct conflict with *Portland Retail Druggists* and should be reversed. The Ninth Circuit's decision is further impaired by its failure to examine whether the complex of profit and nonprofit corporations which constitute the Kaiser Health Plan is a nonprofit organization. *See* n.7, *infra*.

antitrust exemption any particular competitive health care alternative.[3]

In *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378 (1981), the Court declined to imply an exemption from the federal antitrust laws where the basis upon which the implied exemption was sought was a conflict between a national health policy statute and the antitrust laws. It is even more inappropriate to infer an exemption for HMOs where, as in the case of the HMO Act, Congress specifically addressed conflicts between state laws and the HMO Act, but was silent on the relationship between that Act and the federal antitrust laws.[4]

II. The Ninth Circuit's Broad Construction Of The Nonprofit Institutions Act Exemption For "Charitable Institutions" Is Unsupported And Conflicts With The Purposes Of The Robinson-Patman Act

The Ninth Circuit's conclusion that HMOs are charitable institutions within the meaning of the Nonprofit Institutions Act and therefore eligible for exemption from the Robinson-Patman Act is contrary to established principles of antitrust law and, because it is premised upon considerations irrelevant

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[3] The legislative history of the HMO Act makes it clear that Congress did not intend to exempt HMOs from the antitrust laws. The 1973 Act, as well as all of its subsequent amendments, was prepared by the Senate Labor & Public Welfare and the House Interstate & Foreign Commerce Committees, which have jurisdiction over health matters. None of the HMO bills was referred to or reported from the Senate and House Judiciary Committees, which have exclusive jurisdiction over antitrust matters. In fact, the antitrust laws were never mentioned during the debates or in the committee reports on the HMO Act of 1973 or its 1976, 1978 and 1981 amendments.

[4] Congress specifically preempted state laws that impeded establishment of HMOs, since such laws were deemed anticompetitive. Congress never suggested that an exemption from the basic competitive structure established by the federal antitrust laws was appropriate.

to the purposes of the Robinson-Patman Act, fundamentally conflicts with the policies and goals of that Act.

The Ninth Circuit relies upon cryptic statements in the meager legislative history of the Nonprofit Institutions Act as the basis for its broad construction of the term "charitable institutions" in the Act. While the legislative history of the Nonprofit Institutions Act reflects a desire on the part of its drafters to exclude eleemosynary institutions from the scope of Robinson-Patman, it provides no basis for the Ninth Circuit's expansive reliance on the definitions of that term that have subsequently been developed in the state charitable trust laws and tax laws. Indeed, the legislative history of the Nonprofit Institutions Act makes no reference whatsoever to those bodies of law.

The fact that some of the same types of institutions that are exempt from the Robinson-Patman Act are also the beneficiaries of special consideration under tax laws does not justify application of the definitions of charitable institutions developed in this unrelated area of law in the antitrust context. The purposes for which eleemosynary institutions are accorded special consideration under the tax laws are quite separate and distinct from the rationale for the antitrust exemption.

The special consideration given nonprofit institutions under federal tax law reflects a legislative determination that such institutions should operate as inexpensively as possible, free of the financial burden of government. Tax exemptions "redistribute the burden of costs from the actual consumers [of the services or products of exempt institutions] to the citizen at

large." *Jefferson County Pharmaceutical Association v. Abbott Laboratories*, 460 U.S. 150, 158 n.17 (1983).[5]

While the exemption embodied in the Nonprofit Institutions Act is also intended to permit nonprofit institutions to operate as inexpensively as possible, it is a limited exemption which must be construed in light of the purposes of the Robinson-Patman Act. *Portland Retail Druggists*, *supra*, 425 U.S. at 13–14. This Act is intended to ensure fair competition among entities that buy and resell similar products at the same functional level. Eleemosynary institutions are exempt from the Robinson-Patman Act in recognition of the fact that such institutions *do not compete* with other purchasers when they purchase supplies for use in discharging their charitable functions rather than for resale. *See* S. REP. NO. 1769, 75th Cong., 3d Sess. 1 (1938). Application of the Robinson-Patman Act's restrictions to such entities would further no purpose of that Act. HMOs by contrast must fall within the coverage of the Robinson-Patman Act since Congress in passing the HMO Act was specifically intending to encourage the development of a *competitive* entity to provide an alternative in the health care market.

The basis for the antitrust exemption for charitable institutions is, therefore, distinct from the purpose of the exemption

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[5] The Court in that case declined to expand the Nonprofit Institutions Act exemption to include purchases of drugs by hospitals owned by state or municipal entities. After making the observation quoted above, the Court observed that "an exemption from the Robinson-Patman Act could give state agencies a significant *additional* advantage in certain commercial markets, perhaps enough to eliminate marginal or small private competitors." 460 U.S. at 158 n.17 (emphasis in original). The Court thus acknowledged a distinction between tax and antitrust exemptions for charitable institutions. The reasoning in *Jefferson County* is equally applicable to any nonprofit institutions that benefit from these tax exemptions.

under the tax laws.[6] The Ninth Circuit's reliance on present day construction of the term "charitable institution" in the tax and state charitable trust laws is, therefore, misplaced, particularly in light of the established principles that require narrow construction of exemptions from the antitrust laws.[7] The application of the Ninth Circuit's definition to HMOs creates the anomalous result of giving nonprofit HMOs, which Congress assisted in order to encourage competition with other forms of health care, a significant unfair competitive advantage over for-profit HMOs, for-profit hospitals, and retail pharmacies.

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[6] The inapplicability of tax law principles in the antitrust context is underscored further by the inconsistent treatment of respondents' health plan by federal and state tax agencies. While the federal government has accorded respondents' plans tax-exempt status (except to the extent they sell drugs to nonmembers), the State of Oregon has determined that the "Kaiser Foundation Health Plan . . . is a commercial organization and not a charity" and is, therefore, subject to state property tax. G. F. Bartz, Assistant Attorney General, Tax Section, Letter to G. Sullivan, Oregon Department of Revenue, Corporation Audit 1 (August 27, 1982).

[7] Even if the Court were to adopt the construction given to this term by the present day tax and state charitable trust laws, it is highly questionable whether the respondents meet even those criteria since Kaiser revenues are distributed for the private gain of for-profit entities. The physicians who service respondents' members annually receive incentive compensation that varies according to the HMOs' financial performance. In addition, substantial sums are contributed to pension funds by the HMOs on behalf of the physicians. The amounts of these contributions also vary according to the HMOs' financial performance. The significant degree to which the "nonprofit" HMOs reward the for-profit physicians who service their members based upon their financial success raises serious doubts as to whether the HMOs are nonprofit institutions, even under the tax and charitable trust laws.

Assuming, arguendo, the propriety of using present day tax or charitable trust law analogies, it is unclear which definition of the term "charitable institution" should be used. Clearly there are numerous different state and federal tax definitions, and state charitable trust definitions.

III. The Ninth Circuit's Blanket Exemption Of Drugs Purchased By HMOs For Resale To Their Members Is Contrary To The Purposes Of The Robinson-Patman Act And Conflicts With The Court's Decision In *Portland Retail Druggists*

The Nonprofit Institutions Act creates only a limited exemption for sales to eleemosynary institutions, expressly applicable only to purchases of supplies "for [the] own use" of eligible institutions. In *Portland Retail Druggists*, *supra*, the Court interpreted this language narrowly to include only those purchases that are necessary to the discharge of the intrinsic, basic functions of an exempt institution.

In *Portland Retail Druggists* the Court defined the functions which it considered to be "for [the] use" of one of the Nonprofit Institutions Act's enumerated institutions—a hospital. In attempting to apply this approach to an HMO, the Ninth Circuit simply concluded that "any sale of drugs by an HMO to one of its members falls within the basic function of the HMO" because HMOs have an "extraordinary broad institutional function." *DeModena v. Kaiser Foundation Health Plan*, 743 F.2d 1388, 1393 (9th Cir. 1984). This conclusion ignores the fact that Congress has defined the basic functions of an HMO[8] and specifically rejected a bill which would have made drug benefits

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[8] Basic services required for federal qualification under the HMO Act include physician services, inpatient and outpatient hospital services, medically necessary emergency health services, short term outpatient evaluative and crisis intervention mental health services, medical treatment and referral services for abuse of or addiction to alchohol and drugs, diagnostic and therapeutic radiologic services, home health services and certain preventive services. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222 § 1302, 87 Stat. 914 (1973) (codified with some differences in language at 42 U.S.C. § 300e-1).

a required service.[9] Congress expressly declared that the provision of prescription drugs to HMO members is a *supplemental, nonmandatory* HMO service.[10] 42 U.S.C. §§ 300e(b)(1)-(2), 300e-1(1)-(2).

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[9] The Senate version of the 1973 bill required HMOs to provide prescription drugs, directly or through arrangements with other retail pharmacists, and expressed a corollary desire that HMOs evaluate and review their members' drug utilization. S. REP. No. 129, 93d Cong., 1st Sess. 11 (1973). The House bill listed prescription drug services as supplemental health services. H.R. REP. No. 451, 93d Cong., 1st Sess. 21 (1973). The final conference committee version designated the provision of drugs prescribed by HMOs in the course of providing health care services as a supplemental service. H.R. REP. No. 714, 93d Cong., 1st Sess. 30 (1973).

Unlike the provision of hospital and medical services, the retail pharmaceutical industry has been vigorously competitive for many years. Although not expressly acknowledged in the legislative history of the HMO Act, it is clear that remedial action to create a competitive alternative of the sort undertaken in the HMO Act was unnecessary in the retail pharmaceutical industry.

[10] Presently about half of all HMOs offer a drug benefit. Robinson, *The HMO/PPO surge*, *supra* at 48. Typical prescription drug benefit plans available through HMOs allow members, for an additional monthly fee, to purchase drugs at little or no cost. This is the case with respondents' plans. In fact, as many as 30% of Kaiser members do *not* purchase the drug option. Kaiser nonetheless resells prescription drugs to these members. These sales should, under *Portland Retail Druggists*, be treated as walk-ins and should not be exempt. Distribution in this manner is in direct competition with disfavored retail distributors.

Moreover, the profits earned from sales at market-level retail prices of prescription drugs acquired at a significant non-cost-justified reduced price under the Nonprofit Institutions Act exemption obviously affect the overall financial performance of respondents' health plans. The profits derived therefrom ultimately inure to the benefit of the for-profit physicians that service respondents' plan members. *See* n.7 *supra*. Such activities more closely resemble the commercial, for-profit transactions that were deemed nonexempt in *Students Book Co. v. Washington Law Book Co.*, 232 F.2d 49, 50 n.5 (D.C. Cir. 1955), *cert. denied*, 350 U.S. 988 (1956) (sales to self-sustaining campus bookstores of supplies that were resold at a profit held not exempt under Nonprofit Institutions Act), than the activities of an institution purchasing supplies for use in discharging charitable functions.

The Ninth Circuit's conclusion that all sales of drugs by HMOs to their members fall within the basic functions of HMOs is, therefore, contrary to the facts and the plain language of the HMO Act, and finds no support in the legislative history of the HMO Act. Accordingly, drugs purchased by an HMO for dispensation to members are not "for [their] own use" by the HMO within the meaning of the Nonprofit Institutions Act, except to the extent they are dispensed to HMO members by hospitals in a manner consistent with the Court's decision in *Portland Retail Druggists*.[11] To hold as the Ninth Circuit did that HMOs are exempt from the Robinson-Patman Act with respect to all sales of drugs to their members is to grant HMOs a "blank check" to pursue "whatever new venture [the HMOs] find attractive," in direct conflict with the Court's decision in *Portland Retail Druggists*. 425 U.S. at 13.[12]

The legislative history of the HMO Act as indicated above reveals that Congress did not intend to create *favored* channels for retail distribution of pharmaceuticals or the delivery of health care services, but rather to augment the competitive options available to the health care consumer. The legislative

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[11] The Ninth Circuit suggests that fee for service nonprofit hospitals would enjoy a market advantage over HMOs if HMOs did not qualify for an exemption for drugs provided to their members. *DeModena v. Kaiser Foundation Health Plan*, 743 F.2d at 1394. The broad exemption created by the Ninth Circuit for HMOs is not necessary to address this concern. This "problem" could have easily been resolved by applying the Court's decision in *Portland Retail Druggists* to the nonprofit Kaiser hospitals. In fact, what the Ninth Circuit has done is to give nonprofit HMOs an unfair competitive advantage over *all other* retail sellers of prescription drugs.

[12] Respondents have refused to certify to drug suppliers that the drugs they purchase at favored prices are "for their own use," a procedure approved by the Court in *Portland Retail Druggists* as a means for suppliers to protect themselves from antitrust liability under the Robinson-Patman Act. 425 U.S. at 20–21. Moreover, respondents have advised suppliers who have requested such a certificate that they would not continue to deal if the favored prices were conditioned upon the provision of such certification.

history of the Act is replete with comments like those of Senator Kennedy, Chairman of the Health and Scientific Research Subcommittee that conducted hearings on the bill in the Senate:

> Our health care system at the present time is monolithic. This bill seeks to introduce some small degree of pluralism into that system so that the American people may have a choice in determining how they wish to purchase *health care services*—through their family doctor or through an HMO. This legislation would make such a choice possible.

119 CONG. REC. 15,497 (1973) (emphasis supplied).

> I strongly believe that the introduction of diversity and pluralism into our current health care system is desirable. The existence of HMO's [sic], where they have been successful, stimulated healthy innovation and competition in the rest of the health care industry in the area. I believe in competition in the health care industry, and I believe *HMO's* [sic] *are one proven form of health care which can be competitive with the existing system.*

119 CONG. REC. 42,505 (1973) (emphasis supplied). Congress determined in enacting the HMO Act to increase the number of competitive options available to health care consumers by providing federal assistance for the development and operation of HMOs to make them competitive with other, more established health care services. Nowhere in the legislative history, however, is there expressed a desire to grant HMOs an unfair *competitive advantage* over other health care providers or retail pharmaceutical distributors.

The blanket exemption granted by the Ninth Circuit is fundamentally inconsistent with the purposes of the Robinson-Patman Act. As discussed *supra*, the exemptions established in the Nonprofit Institutions Act recognize, in effect, that eleemosynary institutions do not operate "at the same functional level" as other purchasers to the extent they use supplies

for their own intrinsic charitable purposes. To the extent that eligible institutions do not restrict uses of products acquired at favored prices to charitable purposes, however, they do compete at the same functional level as disfavored purchasers and should not benefit from the exemption. Indeed, a House subcommittee investigating practices in the pharmaceutical industry in the 1960s observed that "[t]here is no basis apparent . . . why the mandate of the Robinson-Patman Act should not be applied to discriminatory drug sales favoring nongovernmental institutional purchasers, *profit or nonprofit*, to the extent there is prescription drug competition at the retail level with disfavored retail druggists." H.R. REP. NO. 1983, 90th Cong., 2d Sess. 79 (1968) (emphasis supplied). In *Jefferson County*, *supra*, the Court interpreted this language to mean that "*private* institutional purchases may not facilitate unfair retail competition through sales at discriminatory prices." 460 U.S. at 166 (emphasis in original).

IV. CONCLUSION

The Ninth Circuit's decision is contrary to the policies of the Robinson-Patman Act, the Nonprofit Institutions Act and the Health Maintenance Organization Act. The Ninth Circuit's decision is in conflict with the Court's decisions in *Portland Retail Druggists* and *National Gerimedical*. The Ninth Circuit's decision grants HMOs an unfair competitive advantage over retail druggists and other retail distributors of drugs who compete at the same functional level as HMOs and broadens the Nonprofit Institutions Act exemption beyond the limits intended by Congress and established by the Court in *Portland Retail Druggists*.

WHEREFORE, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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OCTOBER TERM, 1984

MARIO DE MODENA dba
SIXTH AVENUE PHARMACY, et al.,
Petitioners,
v.
KAISER FOUNDATION HEALTH PLAN, INC., et al.,
Respondents.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,
Petitioner,
v.
KAISER FOUNDATION HEALTH PLAN, INC., et al.,
Respondents.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTION PRESENTED

Is the Nonprofit Institutions Act exemption to the Robinson-Patman Act applicable to the purchase of pharmaceuticals by the Kaiser Permanente Medical Care Program for the purpose of fulfilling its health care obligations to its members?

LIST OF PARTIES

Parties to the proceeding in the United States Court of Appeals for the Ninth Circuit were as follows:

Portland Retail Druggists Association, Inc.; Mario DeModena dba Sixth Avenue Pharmacy; Hillcrest North Pharmacy; De Anza View Enterprises; The Apothecary Shop; Edwin Drucker dba Mission Park Pharmacy; Roger W. Born dba MacLay Drug Company; Wellington, Inc; Jewell Pharmacy, Inc.; Eugene Elkin dba Kustner's Medical Square Pharmacy; WVP Corporation; unidentified owners and operators of retail pharmacies in Oregon, Washington and California.

Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Colorado; Kaiser Foundation Health Plan of Ohio (formerly Kaiser Community Health Foundation); Kaiser Foundation Health Plan of the Northwest (formerly Kaiser Foundation Health Plan of Oregon); Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (formerly Kaiser-Georgetown Community Health Plan, Inc.); Kaiser Foundation Health Plan of Connecticut, Inc.; Kaiser Foundation Health Plan of Texas; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; Northwest Permanente/P.C.; Hawaii Permanente Medical Group, Inc.; Ohio Permanente Medical Group, Inc.; Colorado Permanente Medical Group, P.C.; Capital Area Permanente Medical Group, P.C.; Permanente Medical Association of Texas.

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No. 84-1038

In the Supreme Court

OF THE

United States

OCTOBER TERM, 1984

MARIO DE MODENA dba
SIXTH AVENUE PHARMACY, et al.,
Petitioners,

v.

KAISER FOUNDATION HEALTH PLAN, INC., et al.,
Respondents.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,
Petitioner,

v.

KAISER FOUNDATION HEALTH PLAN, INC., et al.,
Respondents.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

SUMMARY OF ARGUMENT

The rule for deciding this case was announced by this Court in *Abbott Laboratories v. Portland Retail Druggists Association*, 425 U.S. 1 (1976), and properly applied by the Court of Appeals in this case. In *Abbott Laboratories*, this Court held that the Nonprofit Institutions Act ("NIA") extends to purchases that further the exempt purchaser's institutional function.

The Kaiser Permanente Medical Care Program ("Program") is a prepaid health care delivery system. Its institutional function is to deliver comprehensive health care to its members, who must utilize Program facilities and health care providers to obtain covered care and services, including prescription drugs. Over 99 percent of the drugs dispensed through Program pharmacies are to Program members, and the Program does not compete in the retail drug market where plaintiffs compete.

Starting as an industrial health plan, the Program first accepted community enrollment in 1945. Today, 40 years later, the Program and other plans on the Program model serve less than four percent of the U.S. population. Program pharmacies are not going to displace community pharmacies.

This is a case for applying the principles enunciated in *Abbott Laboratories*, which the Court of Appeals properly did. The case presents no new question calling for Supreme Court guidance.

STATEMENT OF THE CASE

Kaiser Foundation Health Plan, Inc., and its subsidiary, Kaiser Foundation Health Plan of the Northwest ("Health Plans"), are qualified nonprofit HMOs under the Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e *et seq.*, ("HMO Act"), and are exempt from federal income tax as charitable organizations under Internal Revenue Code § 501(c)(3). The Health Plans, together with Kaiser Foundation Hospitals ("Hospitals") and independent Groups of contracting physicians ("Medical Groups"), constitute the Program.

Under its membership contracts with groups and individuals, each Health Plan assumes responsibility to deliver comprehensive, predominantly prepaid health care

services to its members.[1] Covered health care services include unlimited hospitalization, complete services of physicians in the hospital and in the doctor's office, complete laboratory and x-ray services, prescribed eyeglasses and prescribed drugs, mental health care, medical social services, health education classes, and services of numerous ancillary health professionals. Prescription drugs are an important but comparatively minor element in the total spectrum of health care services provided through the Program.

All Program pharmacies are operated as professional prescription pharmacies, and not as general merchandise outlets. Prescription drugs represent more than 95% of the value of items dispensed, and the only other items dispensed are nonprescription drugs and health care supplies. Most pharmacies are accessible only from an interior hall of the hospital or outpatient medical office facility in which they are located. Only a few pharmacies have direct access to public streets. The pharmacies are not identified by outdoor signs, and the interior signs that identify pharmacy locations are of the same size and style as other directional and informational signs in the Program facility where the pharmacy is located. The Program does not seek non-member drug sales. No promotional, advertising or merchandising activities are conducted by or on behalf of any Program pharmacy.

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[1] Kaiser Foundation Health Plan, Inc. and its eight subsidiary plans operate in 10 geographic areas, called regions. Each Health Plan satisfies its responsibility to provide care principally through two Service Agreements. Under a Medical Service Agreement, the regional Medical Group provides professional and related services. Under a parallel Hospital Service Agreement, Kaiser Foundation Hospitals, a nonprofit and tax-exempt charitable organization, provides hospital and related services.

Health Plans and Hospitals are under common control. Each of the 10 regional Medical Groups is independent of Health Plan, Hospitals, and all other Medical Groups.

A person cannot become just a Program "drug member", but must enroll for comprehensive health care services. The District Court found the Program's negligible non-member sales (less than one percent of the total) to be *de minimis*, but the Court of Appeals remanded for "an evaluation of the impact of [non-member] sales on competition in the retail drug market."

The Health Plans compete not for community drug sales, but at a different functional level and in another market. That market is prepaid health care, and the Program's principal competitors are Blue Cross/Blue Shield, and health insurers such as Metropolitan and Prudential.

The Program first opened to the community in 1945. From its inception until the HMO Act, the Program was called a "group practice prepayment plan". Although group practice prepayment plans are a type of HMO, "HMO" is an umbrella term that covers a number of other, dissimilar arrangements.[2] Principal among these is the individual practice association ("IPA"). "The IPA, often sponsored by local, county, or state medical societies, contracts with providers to deliver services to [IPA] patients from the provider's own office." S. Schmidt, "Health Maintenance Organizations and the McCarran Ferguson Act", 7 *American Journal of Law & Medicine* 437, 438-439 (Winter, 1982).

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[2] ". . . [T]he most highly organized and committed model of an HMO employs physicians of various specialties and other health personnel or has them organized into a closed-panel group practice, and this model uses health facilities which are owned and operated by the HMO. Both the group practice and the HMO are devoted to serving the enrolled population groups full time, with minimal, if any, fee-for-service practice. This model is most closely identified with the Kaiser Foundation Health Plans. . . ." H. R. Rep. No. 451, 93d Cong., 1st Sess. at 10 (1973). See also S. Rep. No. 129, 93d Cong., lst Sess., *reprinted in* 1973 U.S. Code Cong. & Ad. News 3033, 3040.

The Internal Revenue Service will not grant charitable status to IPAs, and there is no basis for believing that they could obtain exemption as "charitable institutions" under the NIA. Moreover, many HMOs are for profit, and obviously are not covered by the NIA.

After more than 40 years of operation, and 10 years after the HMO Act, HMOs of the nonprofit group practice prepayment type, plus other HMOs that might be exempt as charities, serve less than four percent of the U.S. population. See *National HMO Census, 1983* (Interstudy 1983); *December 1983 Enrollment in the U.S., a Midyear Census* (Interstudy 1984).

The picture that the briefs supporting the petition would paint suggests that HMOs are about to monopolize the retail drug business. It is a portrait quite unrecognizable to a Program that after four decades has achieved a two percent market niche in the face of historical opposition from organized medicine and the continuing dominance of the monoliths of prepaid health care arrangements—Blue Cross/Blue Shield and commercial insurers.

REASONS FOR DENYING THE WRIT

1. The Rule for Deciding This Case Was Announced In *Abbott Laboratories*

Nonprofit institutions, as defined by the NIA, are specifically exempt from the Robinson-Patman Act so long as they stay within the bounds of their institutional functions. The first time that the Portland Retail Druggists Association came before this Court, in *Abbott Laboratories, supra*, 425 U.S. 1, there were some uncertainties regarding the NIA's scope. Was the NIA's protection limited only to those types of organizations that existed when the Act was passed? Was its protection limited only to those types of activities which nonprofit institutions

had historically engaged in? Could a nonprofit institution enter into profitable activities unrelated to its basic functions and still claim the protection of the NIA?

This Court accepted *Abbott Laboratories* to answer these questions, and it did. While the exemption is not "to be applied and expanded automatically to whatever new venture the nonprofit [organization] finds attractive in these changing days", it is also not "restricted and confined" to the "nonprofit [organization's] original or 'traditional' status." 425 U.S. at 13. As the Ninth Circuit correctly held, the test "inherent in the language of the statute" is whether the activity in question "is part of and promotes the [organization's] intended institutional operation." *Id.* at 14.

2. Prescription Drugs Dispensed To Members Of The Program Are Covered By The Nonprofit Institutions Act

a. The Health Plans Are Nonprofit and Charitable

Charity as a legal concept is synonomous with community benefit, and is not limited to almsgiving and relief of the poor. *Bob Jones University v. United States*, 461 U.S. 574, ____, 103 S. Ct. 2017, 2027-28, 76 L.Ed.2d 157, 171-72 (1983). "The ultimate test is undoubtedly benefit to the community." IV A. Scott, *Law of Trusts* § 369.2 at 2862 (3rd ed. 1967). "The common element of all charitable purposes is that they are designed to accomplish objects which are beneficial to the community." Restatement (Second) of Trusts § 368 at 247 (1959).

More than a century ago, this Court, applying what it termed "general principles of jurisprudence", said: "A charitable use, where neither law nor public policy forbids, may be applied to almost anything that tends to promote the well-doing and well-being of social man." *Ould v. Washington Hospital for Foundlings*, 95 U.S. 303, 310, 311 (1877). Less than two years ago this Court

quoted these very words as it found that the "public benefit" definition of charity must have been intended by Congress when it enacted I.R.C. § 501(c)(3). *Bob Jones University, supra,* 574 U.S. at ____, 103 S.Ct. at 2027, 76 L.Ed.2d at 171. This Court also noted that, in applying the community benefit definition of charity, courts should look to "contemporary standards." *Bob Jones University, supra,* 574 U.S. at ____, 103 S.Ct. at 2029, n. 20, 76 L.Ed.2d at 174, n. 20.

That is, the "charity" concept is shaped by contemporary perceptions of social need, and the term must be interpreted in its cultural context as an evolutionary rather than fixed idea. Good health always has been an important social goal, and promotion of health therefore has consistently been regarded as a charitable purpose. Restatement (Second) of Trusts § 368 (1959). In this context, the HMO Act and its underlying policy to encourage plans such as the Program evidence a national consciousness that plans on the Program model serve an important contemporary community need and thereby confer an important community benefit.

The NIA explicitly exempts hospitals. Although there have been hospitals for centuries, comprehensive health care delivery systems such as the Program are of comparatively recent origin. The Program and plans like it represent a response to the increasing complexity of health care and the parallel need for increasingly sophisticated arrangements to assure that care is both timely and appropriate, and that it is provided at reasonable cost.

In the context of today's community needs, nonprofit group practice prepayment plans have a better claim to charitable exemption than hospitals. Although hospitals often are community health centers, their core function still is to provide inpatient care to acutely ill or injured patients. However, acute care represents a comparatively

limited element in the aggregate of services that comprise comprehensive health care. The Program, on the other hand, assumes responsibility not simply to provide episodic care, but to assemble and organize the totality of services that comprise comprehensive health care. This is the greater community need, and it is a need that group practice HMOs alone meet. The only reported cases considering the question hold that group practice prepayment plans are charitable. *Sound Health Association v. Commissioner,* 71 T.C. 158 (1978), *acq.*, 1981-2 C.B. 2; *Harvard Com. Health Plan v. Board of Assessors,* 427 N.E.2d 1159 (Mass. 1981).[3]

Moreover, in an era in which runaway health care costs represent a national problem of crisis proportions, group practice HMOs consistently achieve financial savings for their members in the range of 10-40% as compared with traditional insurance or Blue Cross/Blue Shield plans serving similar population groups.[4] The Program emphasizes comprehensive outpatient care and early intervention, thereby reducing the need for costly hospitalization.

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[3] The *amicus* briefs revive a claim that was examined and rejected by both the District Court and the Court of Appeals. This claim is that the method of compensating the Medical Groups partially through a payment that is at risk and contingent upon Program financial results raises doubts about the Health Plans' non-profit status. After reviewing the Medical Groups' compensation arrangements, the Court of Appeals said (743 F.2d 1388, 1391, n. 4):

> "A small portion of the payment to the Medical Groups—generally around five percent of the total payment—does not depend solely upon the number of members in the Medical Group's region. This portion is withheld by the Health Plan and paid to the Medical Groups only if the Program organizations meet their yearly financial goals. This system of payment is designed to give the doctors in the Medical Groups an incentive to keep costs low, and it is required by regulations promulgated pursuant to the Health Maintenance Organizations Act. 42 C.F.R. § 110.104(b)(1)(v)."

[4] Manning, Willard G., et al., "A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services", 310 *The New England*

This characteristic enables the Program to compete effectively against traditional health care coverage.

The Health Plans have never claimed that they are charitable simply because they are qualified group practice HMOs under the HMO Act, nor do they claim that the HMO Act impliedly repeals any antitrust law. The Court of Appeals decision did not mention the concept of implied repeal.

The National Association of Retail Druggists suggests that judicial and administrative determinations that plans on the Program model are charitable for purposes of tax exemption is irrelevant in the antitrust context (NARD Brief at 9-11). However, the underlying policy of both exemptions is to free charitable institutions from constraints and impositions that otherwise would apply. The tax cases referred to and the Internal Revenue Service's determination that plans like the Program are tax exempt is founded on a determination of their charitable character under the general community benefit standard, and there is nothing in the NIA that suggests a different standard.

The National Association of Retail Druggists' statement that the organizations covered by the NIA do not compete with other purchasers (NARD Brief at 12) ignores the NIA's explicit exemption of nonprofit hospitals, which of course directly compete with proprietary (for-profit) hospitals, and the NIA's exemption of nonprofit schools, which compete with for-profit schools, particularly at the secondary level.

Journal of Medicine 1505 (June 7, 1984); H. Luft, *Health Maintenance Organizations: Dimensions of Performance* at 387 (John Wiley & Sons, Inc. 1981); H. Luft, "How Do Health Maintenance Organizations Achieve Their 'Savings'?", 298 *The New England Journal of Medicine* 1336, 1337 (July 15, 1978).

The test of charity is thus not absence of competition, it is whether the institution confers the requisite community benefit. At the same time, we again note that the Program does not compete in the plaintiffs' market, but is almost exclusively devoted to serving its members.

b. The Program's Drug Purchases Are For Its Own Use

In *Abbott Laboratories, supra,* 425 U.S. at 14, this Court said that in applying The NIA's "own use" standard to drug sales by hospitals:

> "... 'their own use' is what reasonably may be regarded as use *by the hospital* in the sense that such use is a part of and promotes the hospital's intended institutional operation in the care of persons who are its patients."

The "own use" standard applicable to a hospital was analyzed by this Court in *Abbott Laboratories* in terms of user categories and their relation to the hospital's institutional function. Whereas hospitals have relationships with *patients,* the Program has relationships with *members,* who by the terms of their membership contracts are entitled to comprehensive benefits but must utilize Program facilities and services to obtain these benefits, including prescription drugs. In contrast to the historical hospital/patient relationship, which is limited to the duration of the inpatient stay, the Program and its members have a continuing relationship. The Program acquires and dispenses drugs to all members because it is essential to the Program concept of comprehensive care that appropriate drug therapy be integrated as part of members' health care. Thus, except for negligible non-member sales, all drugs acquired and dispensed through Program pharmacies are for the Program's "own use" in meeting its contractual obligations to members.

CONCLUSION

The legal issue raised by the petition is whether the Ninth Circuit correctly applied the *Abbott Laboratories* test. As such the petition raises no new or novel issues requiring Supreme Court guidance. Furthermore, the Ninth Circuit was right. The petition should be denied.

Respectfully submitted,

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MOTION OF AMERICAN PHARMACEUTICAL ASSOCIATION FOR LEAVE TO FILE BRIEF AS AMICUS CURIAE IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI AND BRIEF AMICUS CURIAE

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Counsel for the Petitioners has consented to the filing of the attached brief. Counsel for the Respondents have not consented to its filing.

The American Pharmaceutical Association (APhA) is a nonprofit, membership corporation organized and existing under the laws of the District of Columbia since 1852. It is the national professional society of pharmacists in the United States, and its membership consists of about 38,000 practicing pharmacists, pharmaceutical scientists and educators. Additionally, about 12,000 students enrolled in colleges of pharmacy hold student membership in APhA.

APhA member pharmacists practice their profession in a variety of settings. Some are owners of community pharmacies. Other are employed pharmacists in community pharmacies and in both nonprofit and for-profit hospitals. Yet others serve in the Armed Forces and in government and private health care administration positions. A substantial number of APhA members are employed by Health Maintenance Organizations. APhA itself has no commercial interest in any pharmacy, nor does it represent the proprietary interest of pharmacist owners of community pharmacies as such.

APhA and, of course, its members are vitally interested in the public health and welfare as they may be affected by the profession of pharmacy. In that regard, APhA's contemporary purpose is to render assistance in improving, promoting, and safeguarding the public health and welfare by: (A) participating in a system of education and training for pharmacists and recommending standards of professional practice; (B) disseminating knowledge to promote the safe and effective use of drugs; (C) encouraging and maintaining relations with other health professions; (D) participating as representative of the profession of pharmacy in the processes of government; (E) encouraging interest in the practice of pharmacy as a professional career and supporting systems of educational accreditation and licensure; (F) providing and maintaining a Code of Ethics for pharmacists; (G) fostering research; and (H) pursuing such other lawful purposes within its corporate powers as may be approved from time to time by its members or Board of Trustees.

Community pharmacists today are licensed professional practitioners, and those owning pharmacies are simultaneously small business proprietors in a highly competitive market for pharmaceutical services. APhA and its members vigorously support the American free enterprise system which provides the only meaningful climate under which professionals and small businesses can survive economically, have the opportunity to succeed by their own efforts, and perform essential health care services to their communities. APhA is dedicated to the preservation of a competitive market place.

APhA and its members have a vital interest in assuring the continued widespread availability of pharmaceutical service to the public when and where such service is required. For many persons, the pharmacist is the most readily-accessible health care professional and, in addition to providing generally-recognized drug information and dispensing services, the pharmacist often serves as an initial point of contact or entry for those persons not having a regular relationship with the health care system or its professional practitioners.

APhA recognizes that the realities of pharmacy practice, as that practice has developed uniquely in this country, include various means and agencies through which pharmaceutical service is provided to the public under different social, economic and health care requirements. The only issue in the instant case, however, involves the providing of pharmaceutical service by asserted nonprofit and "charitable" Health Maintenance Organizations to individuals for whose patronage other providers of pharmaceutical service compete. Under the Ninth Circuit opinion, such Health Maintenance Organizations enjoy an overwhelming anti-competitive advantage.

Your amicus is dedicated to preserving consumer choice of pharmaceutical service to meet public health needs. APhA recognizes, however, that this objective will fail if any segment of competing pharmaceutical service providers is economically disadvantaged so as to be eliminated or threatened with elimination.

WHEREFORE, the American Pharmaceutical Association requests this Court to grant this motion and permit the Association to file the brief amicus curiae attached hereto.

Respectfully submitted,

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BRIEF OF AMERICAN PHARMACEUTICAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

PRELIMINARY STATEMENT

The American Pharmaceutical Association (APhA) submits this brief amicus curiae in support of the Petitioners, Mario DeModena, dba Sixth Avenue Pharmacy, et al., and Portland Retail Druggists Association, Inc.

INTEREST OF AMICUS

The American Pharmaceutical Association (APhA) is a nonprofit, membership corporation organized and existing under the laws of the District of Columbia since 1852. It is the

national professional society of pharmacists in the United States, and its membership consists of about 38,000 practicing pharmacists, pharmaceutical scientists and educators. Additionally, about 12,000 students enrolled in colleges of pharmacy hold student membership in APhA.

APhA member pharmacists practice their profession in a variety of settings. Some are owners of community pharmacies. Others are employed pharmacists in community pharmacies and in both nonprofit and for-profit hospitals. Yet others serve in the Armed Forces and in government and private health care administration positions. A substantial number of APhA members are employed by Health Maintenance Organizations. APhA itself has no commercial interest in any pharmacy, nor does it represent the proprietary interests of pharmacist owners of community pharmacies as such.

APhA and, of course, its members are vitally interested in the public health and welfare as they may be affected by the profession of pharmacy. In that regard, APhA's contemporary purpose is to render assistance in improving, promoting, and safeguarding the public health and welfare by: (A) participating in a system of education and training for pharmacists and recommending standards of professional practice; (B) disseminating knowledge to promote the safe and effective use of drugs; (C) encouraging and maintaining relations with other health professions; (D) participating as representative of the profession of pharmacy in the processes of government; (E) encouraging interest in the practice of pharmacy as a professional career and supporting systems of educational accreditation and licensure; (F) providing and maintaining a Code of Ethics for pharmacists; (G) fostering research; and (H) pursuing such other lawful purposes within its corporate powers as may be approved from time to time by its members or Board of Trustees.

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APhA and its members have a vital interest in assuring the continued widespread availability of pharmaceutical service to the public when and where such service is required. For many persons, the pharmacist is the most readily-accessible health care professional and, in addition to providing generally-recognized drug information and dispensing services, the pharmacist often serves as an initial point of contact or entry for those persons not having a regular relationship with the health care system or its professional practitioners.

APhA recognizes that the realities of pharmacy practice, as that practice has developed uniquely in this country, include various means and agencies through which pharmaceutical service is provided to the public under different social, economic and health care requirements. The only issue in the instant case, however, involves the providing of pharmaceutical service by asserted nonprofit and "charitable" Health Maintenance Organizations to individuals for whose patronage other providers of pharmaceutical service compete. Under the Ninth Circuit opinion, health maintenance organizations enjoy an overwhelming anti-competitive advantage.

Your amicus is dedicated to preserving consumer choice of pharmaceutical service to meet public health needs. APhA recognizes, however, that this objective will fail if any segment of competing pharmaceutical service providers is economically disadvantaged so as to be eliminated or threatened with elimination.

ARGUMENT

THE NINTH CIRCUIT ERRED IN HOLDING THAT RESPONDENT HMO'S ARE "CHARITABLE INSTITUTIONS" UNDER THE NONPROFIT INSTITUTIONS ACT EXEMPTION TO THE ROBINSON-PATMAN ACT

The holding of the court below that the Health Maintenance Organizations involved in this litigation are eligible for exemption as "charitable institutions" is contrary to obvious fact, and has no foundation in law. In addition, the superficial analysis of this critical issue found in the Ninth Circuit's opinion is utterly contrary to prior decisions of this Court construing the Robinson-Patman Act and the limited Nonprofit Institutions Act exemption.

The Ninth Circuit's opinion wrongly departs from well established antitrust policy and analysis. In reaching the unfounded conclusion that respondent HMOs are "charitable institutions" the court below wholly ignored the massive market power of the Kaiser-Permanente Medical Care conglomerate and its highly commercialized marketing orientation. The Kaiser-Permanente Medical Care Program Annual Report for 1983 (inside cover) describes the organization in the following terms:

> The Program is a joint endeavor involving representatives of the professions of medicine and management, sharing responsibilities for organizing, financing and delivering quality health care services on a prepaid basis. Medicine is represented by separate and independent Permanente Medical Groups, and Management by Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals. The Program serves more than 4,400,000 voluntarily enrolled members in California, Colorado, Hawaii, Ohio, Oregon, Washington, Texas, the metropolitan Washington, D.C. area and Connecticut.

The Kaiser Foundation Health Plan Financial Statement for 1982 and 1983 which is reproduced in its entirety in the

Appendix at 1a reflects that in 1983 the organization had total revenues in excess of $2.9 billion. Expenditures for 1983 reflect that $2.7 billion was spent for medical services, while approximately $73 million was spent for "Health Plan Administration." App. at 2a. The corporation reported a net worth in 1983 in excess of $611 million. App. at 12a. These are extremely impressive figures for a alleged non-profit "charitable institution." Kaiser-Permanente is by far the largest Health Maintenance Organization in the country with over seven times the enrollment of its nearest competitor. App. at 2b. A recent interview with a Kaiser Vice President indicated that the conglomerate has every intention of expanding its market penetration in the years to come.

> In a race to establish national networks, Kaiser Foundation Health Plan, Inc. the largest HMO, is spending $300 million on expansion this year, [1984] according to Robert J. Erickson, senior vice president. He said *Kaiser plans to spend $2 billion in the next five years.* From its California base, Kaiser has jumped to nine other states and the District of Columbia. It added 200,000 members this year, for a total of 4.6 million. Revenues passed $3 billion.
>
> In 1985, Kaiser will add three more states, including New York, where it plans to expand the Westchester Community Health Plan, a small HMO in White Plains (emphasis added).

New York Times. Dec. 17, 1984 (App. at 3b)

Your amicus respectfully submits that the respondents, which look and act like a "Fortune 500" conglomerate, cannot be treated as "charitable institutions" for purposes of the application of the antitrust laws. The immense market power and capability for expanding that market power evidenced by the foregoing report constitutes a serious threat to competition to providers of pharmaceutical service. If the Ninth Circuit's view prevails, expansive HMOs possessing financial strength far in excess of the resources of independent community pharmacies, or even drug store chains will enjoy an exemption from the discriminatory pricing protections of the antitrust laws.

Such a result would defeat the fundamental purpose of the Robinson-Patman Act and circumvent the limited purpose of the Nonprofit Institutions Act as earlier construed by this Court. That purpose is to provide financial relief to struggling eleemosynary institutions.

On numerous occasions, this Court has affirmed the comprehensive coverage of the antitrust laws and has recognized that those laws represent "a carefuliy studied attempt to bring within the [antitrust laws] every person engaged in business whose activities might restrain or monopolize commercial intercourse among the states." *United States v. South-Eastern Underwriters Ass'n.*, 322 U.S. 533, 553 (1944). This court has also strictly construed any asserted exclusions from those laws. In *Jefferson City Pharmaceutical Ass'n v. Abbott Laboratories*, 460 U.S. 150 (1983) this Court held that:

> It has been said, of course, that the antitrust laws, and Robinson-Patman in particular, are to be construed liberally, and that the exceptions from their application are to be construed strictly. (citations omitted). The Court has recognized, also, that Robinson-Patman 'was enacted in 1936 to curb and prohibit all devices by which large buyers gained discriminatory preferences over smaller ones by virtue of their greater purchasing power.' (citations omitted). Because the Act is remedial, it is to be construed broadly to effectuate its purposes. (citations omitted).

460 U.S. at 159. The Court then held that the sale of pharmaceutical products to state and local government hospitals for resale in competition with private pharmacies is not exempt from the proscriptions of the Robinson-Patman Act. The view that Robinson-Patman Act constraints should apply to HMO purchases for resale in marketplace competition with retail pharmacies is further buttressed by this Court's decision in *Abbott Laboratories v Portland Retail Druggists Ass'n.*, 425 U.S. 1 (1976). There, interpreting the Nonprofit Institutions Act the Court construed the limited exemption provided for purchases made by designated nonprofit institutions "for their own use." 425 U.S. at 14. This court held that not all purchases

were thereby exempted from the Robinson-Patman Act, recognizing that were a nonprofit hospital allowed to purchase and sell drugs to all individuals (particularly "walk-in" patients) at a price less than that available to commercial pharmacies, the hospitals would be "devastatingly positioned with respect to competing pharmacies." 425 U.S. at 18.

The same rationale is applicable in the instant case. If the thinking of the Ninth Circuit is allowed to stand by this Court and Health Maintenance Organizations are permitted to buy drugs at lower prices than other pharmacies, and sell those drugs without restriction, there would result a severe distortion and disruption of the marketplace, a condition which the antitrust laws were intended to prevent. Such a result would reinstitute the chaotic marketplace situation thought by many to have been cured by this Court's decision in *Abbott Laboratories v. Portland Retail Druggists Ass'n., supra.* Now, Health Maintenance Organizations may be arrayed against and "devastatingly positioned," with respect to both government and non-government hospitals and community pharmacies. If the Ninth Circuit's opinion is allowed to stand, all other pharmaceutical service providers will remain subject to the Robinson-Patman Act, while $3 billion a year "nonprofit" HMOs will be exempt. Surely, in 1938, the architects of the Nonprofit Institutions Act did not contemplate and would not sanction such a result.

As noted above, the Ninth Circuit's conclusory pronouncement of what constitutes a "charitable institution" is superficial and is totally lacking in historical and economic analysis. The term "charitable" has been given formal recognition in the law for centuries, as the term emanates from the common law of charitable trusts. The general rule is that the word "charitable" at common law encompassed "trusts for the relief of poverty; trusts for the advancement of education, trusts for the advancement of religion; and trusts for other purposes beneficial to the community, not falling under any of the proceeding heads." B. HOPKINS, THE LAW OF TAX-EXEMPT ORGANIZATIONS (1983) at 45-48.

The term "charitable," under the English common law, was a most encompassing term, yet it remained a definable legal concept. The definition of the term "charitable" dates back to the definition of charitable purposes in the Preamble to the Statute of Charitable Uses of 1601. (Stat. 43 Eliz. I, c.4) The Statute itself is based upon holdings of the English Court of Chancery before 1601 and upon earlier experiences (such as the Codes of Justinian) of previous civilizations including those of Rome and Greece and early Judaism, as well as in many other early cultures and religions. The Statute enumerates certain "charitable" purposes, as follows:

> . . . some for relief of aged, impotent and poor people, some for maintenance of sick and maimed soldiers and mariners, schools of learning, free schools, and scholars in universities, some for repair of bridges, ports, havens, causeways, churches, sea-banks, and highways, some for education and preferment of orphans, some for or towards relief, stock or maintenance for houses of correction, some for marriages of poor maids, some for supportation, aid and help of young tradesmen, handicraftsmen and persons decayed, and others for relief or redemption of prisoners or captives, and for aid or ease of any poor inhabitants concerning payments of fifteens, setting out of soldiers and other taxes.

These and other classifications of the concept of charity were discussed by Lord Macnaghten in 1891, who said:

> Of all words in the English language bearing a popular as well as a legal significance I am not sure that there is one which more unmistakably has a technical meaning in the strictest sense of the term, that is a meaning clear and distinct, peculiar to the law as understood and administered in this country, and not depending upon or coterminous with the popular or vulgar use of the word.

Lord Macnaghten's discussion was cited with approval by this Court in *Evans* v. *Newton,* 382 U.S. 296, 308 (1966) (White, J., concurring). The term, "charitable," then, has a legal meaning

and is regarded as a term of art, while terms such as "philanthropy" remain popularized words lacking in legal significance.

The Ninth Circuit ignored the time honored common law definition of "charitable" and "charitable institution" which has developed over many years of English and American jurisprudence. As Professor Oleck in his well known treatise states:

> Charitable means liberal to those in need. It is equivalent to benevolent, beneficient, or eleemosynary. Eleemosynary itself means pertaining to the distribution of alms or bounty. Thus, an eleemosynary corporation is a corporation organized for the accomplishment of charitable or benevolent purposes.
>
> * * *
>
> A *charitable institution* is one devoted to performing a public service or one supported at least in part by public aid, or one that administers a charity.

H. OLECK, NON-PROFIT CORPORATIONS, ORGANIZATIONS AND ASSOCIATIONS (3rd Ed. 1976) at 578. The fundamental legal principle underlying every charitable organization is the care of the poor and needy.

The record reflects that the respondents are not "charitable" because they are not organized to care for the poor and in the absence of emergency do not give medical care to the indigent. They are in the business of selling medical care only to families who can afford to pay $2,000 per year (or receive coverage as a fringe benefit of employment). See App. at 2b.

The financial structure of the organization belies all claim to charitable status under the law. The realities of its financial structure as a "joint endeavor" with for-profit entities demonstrate clearly that the organization is not eleemysonary. In 1983 Kaiser generated 2.7 billion dollars in "Medical Expenses" which were paid to for-profit corporations. App. at 2a. The balance of 73 million dollars in expenses were paid to the administration of the health plan. *Id.* This financial arrangement constitutes a combination which clearly produces substan-

tial profits for the Medical Group partnerships and the Permante Service Corporation which are emphatically not "charitable institutions" entitled to exemption.

On a functional level, HMOs are competing head to head with other health plans and traditional health care providers for the consumer health dollar. The fact that an HMO is "nonprofit" does not render it exempt from the antitrust laws.

Respondents are not only large and powerful (whether they be nonprofit or for-profit) but they compete in the American economy precisely like any other business. This is graphically demonstrated by the following excerpt from a recent publication of the U.S. Department of Health and Human Services entitled *Guide to Development of Health Maintenance Organizations* (1982).

Subtask 3.1: Analyze Market Shares

Exhibit IV-16

Market Share Analysis

Carrier	X	Y	Z	HMO X	HMO Y	Others	Total
Market Share...	40%	25%	10%	5%	3%	17%	100%

When analyzing the resulting picture of the market, the HMO planner should pay particular attention to whether the market is concentrated or fragmented. In general, if one or two carriers dominate, then the market will be difficult to penetrate. The HMO should consider possible competitive reactions by a dominant carrier—reducing or holding premiums constant, massive advertising campaigns—and estimate its own ability to counteract such moves. A fragmented marketplace (unless there are several HMOs) will be easier to penetrate and existing competitors will have less leverage in developing counter-strategies.

Id., at IV 32

HMOs with the financial power to monopolize the pharmaceutical service market who exhibit the aggressive marketplace intent and behavior of the respondents are and ought to be subject to the Robinson-Patman Act.

CONCLUSION

APhA is dedicated to the preservation of adequate pharmaceutical service to meet public needs. This objective will fail if one segment of competing pharmaceutical service providers is economically disadvantaged so that it is eliminated or threatened with elimination. There is no interest sufficient to sanction the operation of health maintenance organizations and their pharmacies outside of the coverage of the antitrust laws when the result would be a disruption of a free marketplace. Your amicus respectfully urges this Court to grant the petition for writ of certiorari and reverse the decision of the Ninth Circuit below.

Respectfully submitted,

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APPENDIX A

KAISER FOUNDATION HEALTH PLAN, INC.
AND SUBSIDIARIES
AND KAISER FOUNDATION HOSPITALS

Financial Statements

Years Ended December 31, 1983 and 1982

KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS

COMBINED STATEMENTS OF NET INCOME AND CHANGES IN FINANCIAL POSITION

Amounts in Thousands

	Years Ended December 31			
	1983		1982	
REVENUES:				
Members' dues	**$2,356,612**	**80.0%**	$1,956,526	80.0%
Supplemental charges to members	**110,430**	**3.7**	94,313	3.9
Medicare, Health Plan members	**385,119**	**13.1**	305,990	12.5
Nonplan and industrial	**70,190**	**2.4**	69,322	2.8
Other	**22,937**	**.8**	18,477	.8
TOTAL REVENUES	**2,945,288**	**100.0**	2,444,628	100.0
EXPENSES:				
Medical services	**1,439,007**	**48.8**	1,188,850	48.6
Hospital services	**992,233**	**33.7**	842,942	34.5
Outpatient pharmacy and optical services	**171,532**	**5.8**	139,465	5.7
Other benefit costs	**137,463**	**4.7**	106,496	4.4
Community service programs, less $5,088 and $5,905 from research grants and contracts	**26,893**	**.9**	22,865	.9
TOTAL MEDICAL AND HOSPITAL SERVICES	**2,767,128**	**93.9**	2,300,618	94.1
Health Plan administration	**73,557**	**2.5**	70,168	2.9
TOTAL EXPENSES	**2,840,685**	**96.4**	2,370,786	97.0
NET INCOME—RETAINED FOR CAPITAL REQUIREMENTS	**104,603**	**3.6%**	73,842	3.0%
Add back noncash charges to operations for depreciation of buildings and equipment	**96,073**		81,994	
FUNDS GENERATED FROM OPERATIONS	**200,676**		155,836	

	Years Ended December 31	
	1983	1982
OTHER SOURCES OF FUNDS:		
Decrease in working capital (Note H)	**10,997**	97,124
Proceeds from long-term borrowings	**142,578**	13,922
Increase (Decrease) in:		
Liability for physicians' retirement plan benefits	**24,856**	26,164
Noncurrent revenue deferred to reduce dues rates	**21,718**	(1,592)
Noncurrent liability for self-insured losses	**15,579**	4,944
TOTAL SOURCES OF FUNDS	**$ 416,404**	$ 296,398
APPLICATIONS OF FUNDS:		
Additions to land, buildings and equipment	**$ 282,056**	$ 252,385
Investments designated for facilities expenditures (Note D)	**76,869**	—
Additions to cash and securities segregated for physicians' retirement plan obligation	**24,856**	26,164
Principal payments on long-term debt	**7,799**	15,253
Acquisition of North Central Connecticut Health Maintenance Organization, Inc. and Kaiser/Prudential Health Plan, Inc. (Note B)	—	5,738
Other	**24,824**	(3,142)
TOTAL APPLICATIONS OF FUNDS	**$ 416,404**	$ 296,398

See notes to consolidated financial statements

COMBINED BALANCE SHEETS

Amounts in Thousands

	December 31	
	1983	1982
ASSETS		
CURRENT ASSETS:		
Cash, including interest-bearing deposits and short-term investments	**$ 128,095**	$ 27,047
Accounts receivable:		
Members' dues	**70,348**	63,697
Medicare	**39,606**	25,781
Patients, less allowance for uncollectible accounts of $14,209 and $9,981	**44,404**	40,501
Other	**7,278**	10,886
	161,636	140,865
Inventories	**33,493**	31,625
Prepaid expenses	**12,013**	7,126
TOTAL CURRENT ASSETS	**335,237**	206,663
CASH AND SECURITIES SEGREGATED FOR PHYSICIANS' RETIREMENT PLAN OBLIGATION (Note C)	**295,335**	270,479
INVESTMENTS DESIGNATED FOR FACILITIES EXPENDITURES (Note D)	**76,869**	—
LAND, BUILDINGS AND EQUIPMENT (Note D):		
Land	**131,358**	112,525
Buildings and improvements	**1,085,908**	931,371
Equipment	**330,896**	273,995
Construction in progress	**249,867**	205,698
	1,798,029	1,523,589
Less accumulated depreciation	**593,698**	503,944
	1,204,331	1,019,645
OTHER ASSETS	**24,515**	10,110
	$1,936,287	$1,506,897

	December 31	
	1983	1982
LIABILITIES AND NET WORTH		
CURRENT LIABILITIES:		
Accounts payable and accrued expenses	$ 180,515	$ 127,505
Due to associated medical groups	63,514	46,697
Payroll and related charges	97,316	81,764
Liability for self-insured losses (Note A)	47,187	37,060
Due collected in advance	49,013	43,983
Revenue deferred to reduce dues rates (Note A)	18,160	6,132
Other liabilities	46,000	31,570
Current installments on long-term debt	26,197	13,620
TOTAL CURRENT LIABILITIES	527,902	388,331
LIABILITY FOR PHYSICIANS' RETIREMENT PLAN BENEFITS (Note C)	295,335	270,479
LIABILITY FOR SELF-INSURED LOSSES, less current portion (Note A)	107,190	91,611
REVENUE DEFERRED TO REDUCE DUES RATES, less current portion (Note A)	29,568	7,850
LONG-TERM DEBT, less current installments (Note D)	365,222	243,020
CONTINGENCY (Note G)		
NET WORTH (Note F)	611,070	505,606
	$1,936,287	$1,506,897

See notes to combined financial statements

KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS

NOTES TO COMBINED FINANCIAL STATEMENTS

Years Ended December 31, 1983 and 1982

NOTE A—Summary of Accounting Policies

General

The accompanying combined financial statements include Kaiser Foundation Health Plan, Inc. and subsidiaries—Kaiser Foundation Health Plan of Oregon, Kaiser Foundation Health Plan of Ohio, Kaiser Foundation Health Plan of Colorado, Kaiser-Georgetown Community Health Plan, Inc., Kaiser Foundation Health Plan of Texas, Kaiser Foundation Health Plan of Connecticut, Inc. (Health Plans) and Kaiser Foundation Hospitals (Hospitals).

Health Plans are nonprofit corporations whose capital is available for health care purposes. Hospitals is a nonprofit and charitable corporation whose capital is available only for charitable, educational, research and other hospital purposes, including construction of facilities and retirement of debt. With minor exceptions, income is exempt from federal and state income taxes. Intercompany balances and transactions have been eliminated.

Eight independent Medical Groups cooperate with Health Plans and Hospitals in the conduct of the Kaiser-Permanente Medical Care Program; however, their operations are not included in the combined financial statements. Health Plans contract with Hospitals and the Medical Groups to provide hospital and medical services to their members. Contract payments to the Medical Groups represent a substantial portion of the expenses of medical services reported in the statements of net income.

Revenue Recognition

Members' dues are recorded as revenue in the month for which members are entitled to service. Dues collected in advance are deferred.

Medicare revenue is subject to audit and possible retroactive adjustment. Provision has been made for estimated retroactive adjustments to the extent the probable outcome of such audits can be determined.

Approximately 8.7% and 8.3% of total revenue was derived under contracts with the United States Office of Personnel Management in 1983 and 1982, respectively.

Inventories

Inventories are valued at approximately the lower of cost (first-in, first-out method) or market.

Physicians' Retirement Plan

Securities segregated for physicians' retirement plan obligation are carried at cost. Interest earned and gain or loss on sale of the securities are added directly to, or deducted from, the recorded liability for physicians' retirement plan benefits. The remainder of the plan cost is charged to operations and added to the recorded liability.

Land, Buildings and Equipment

Land, buildings and equipment are stated at cost. Buildings and equipment are depreciated over estimated useful lives principally using accelerated methods. Depreciation included in expenses in 1983 and 1982 was $96,073,000 and $81,994,000, respectively. Pro forma depreciation expense and related accumulated depreciation amounts on a straight-line basis would be as follows:

	1983	1982
Straight-line depreciation	**$ 74,786,000**	$ 64,031,000
Accumulated depreciation at end of year	**$424,312,000**	$355,845,000

Expenditures for maintenance and repairs are charged to operations; expenditures for betterments and renewals which extend lives are capitalized. Gains or losses on retirements and disposals are included in operating results.

Other Assets

Included in other assets are start-up costs which are deferred and amortized over periods of three to five years, bond reserve funds, and debt issue expenses.

Pension Plans

The accrued costs of employee pension plans are funded currently. Accrued costs include the amortization of unfunded prior service costs over periods not exceeding 40 years.

Self-Insured Losses

Annual costs associated with self-insured losses (primarily for professional liability) are charged to operations based upon claims that have arisen during the year and reasonable estimates, based upon the experience of prior years, of losses incurred for which claims had not been filed prior to the end of the year. Such costs will be paid out over a period of years. The portion of such costs estimated to be payable during the next year is included in current liabilities.

Revenue Deferred to Reduce Dues Rates

Health Plans and one or more of the Medical Groups may agree that amounts of unanticipated revenue or cost savings would have been reflected as a reduction of members' dues rates for the current year had such additional revenue or cost savings been known or foreseeable at the time of establishing such rates. Agreements with the Medical Groups provide that these amounts will be carried forward to reduce dues rates in subsequent years. Because of these contractual understandings, Health Plans do not recognize these amounts in determining revenues of the current year. The portion to be applied during the next year is included in current liabilities.

Prior Year Financial Statements

Certain amounts for the prior year have been reclassified to conform to the 1983 presentation.

NOTE B—Acquisitions

Kaiser Foundation Health Plan, Inc. assumed control of North Central Connecticut Health Maintenance Organization, Inc. on July 1, 1982 and Kaiser/Prudential Health Plan, Inc. on April 20, 1982. The names of the plans were changed to Kaiser Foundation Health Plan of Connecticut, Inc. and Kaiser Foundation Health Plan of Texas, respectively. Liabilities exceeded assets acquired by $2,863,000 and $2,875,000, respectively, and these amounts have been treated as reductions of retained income in the combined balance sheets. The statements of net income include the operating results of these plans since their dates of acquisition.

NOTE C—Physicians' Retirement Plan

Certain of the Health Plans have a retirement plan that covers some physicians serving Health Plan members. The plan provides for defined retirement and disability benefits determined by length of service and level of compensation of each participating physician. Prior service costs are amortized over a period of 30 years. The plan is not subject to the Employee Retirement Income Security Act of 1974.

The following is a summary of changes in the liability for physicians' retirement plan benefits:

	1983	1982
Balance at January 1	**$270,479,000**	$244,315,000
Provision for the year	**5,231,000**	3,853,000
Net income from segregated assets	**23,737,000**	25,145,000
Benefits paid	**(4,112,000)**	(2,834,000)
Balance at December 31	**$295,335,000**	$270,479,000

The recorded liability is approximately equal to the actuarial present value of accumulated plan benefits. Cash and marketable fixed income securities with a cost equal to the liability have been segregated. These assets are general assets of Kaiser Foundation Health Plan, Inc. and the claims of participants in the retirement plan have no preferred status or other priority over claims of other general creditors. The quoted market value of the securities held at December 31, 1983 was approximately $11 million less than cost. As of December 31, 1983 the yield to maturity on these securities, based on cost, was 10.5%. Certain Medical Groups have adopted their own qualified retirement plans.

NOTE D— Long-Term Debt, Bank Lines of Credit and Construction of Facilities

	December 31	
	1983	1982
Mortgage notes:		
6% to 10% due 1984 to 2000..	**$171,425,000**	$172,000,000
Unsecured debt:		
Note due 1987—13.5%.....	**40,000,000**	40,000,000
California Health Facilities Authority:		
Serial and Term Bonds due 1984 to 2013—5% to 9.125%.....	**75,000,000**	—
Semiannual Tender Bonds due 2013—5.6% adjustable beginning April 1, 1984	**60,000,000**	—
Other.....	**44,994,000**	44,640,000
	391,419,000	256,640,000
Less current installments on long-term debt.....	**26,197,000**	13,620,000
	$365,222,000	$243,020,000

During 1983 the California Health Facilities Authority issued bonds for the benefit of Hospitals in the amount of $135,000,000 to be used for facilities expenditures. At December 31, 1983 unexpended proceeds from these bonds were $76,869,000. Bonds reserve funds required by the agreements amounting of $10,852,000 are included in other assets.

Required principal payments on long-term debt are $26,197,000 in 1984, $28,895,000 in 1985, $33,652,000 in 1986, $39,719,000 in 1987, $18,744,000 in 1988 and varying annual payments through 2013. Maturities are based on contractual agreements. Repurchase of tender bonds may be required at earlier dates at the holder's option. Substantially all land, buildings and equipment are pledged as collateral for mortgage notes and other notes payable. Interest cost incurred during 1983 was $32,710,000 of which $14,039,000 was capitalized. Interest cost incurred during 1982 was $26,650,000 of which $11,337,000 was capitalized. The organizations are in compliance with restrictive covenants in financing agreements.

Hospitals has bank lines of credit totaling $25 million which expire in 1984. No amounts were outstanding at December 31, 1983.

Facility expenditures not yet incurred for projects undertaken through 1983 and those approved for commencement during 1984 aggregated approximately $645 million at December 31, 1983. These projects are scheduled for substantial completion by the end of 1987.

NOTE E—Pension Plans

Health Plans and Hospitals have several pension plans covering substantially all of their employees. Annual contributions to the plans equal the amounts accrued for pension

expense. A comparison of accumulated plan benefits and plan net assets of defined benefit plans at the most recent valuation date is:

	January 1	
	1983	1982
Actuarial present value of accumulated plan benefits:		
Vested	**$ 80,044,000**	$64,083,000
Nonvested	**17,733,000**	14,876,000
	$ 97,777,000	$78,959,000
Net assets, at market, available for benefits	**$116,224,000**	$78,175,000

The assumed rate of return used in determining the actuarial present value of accumulated plan benefits was 7.0% for both 1983 and 1982.

The total pension expense for 1983 and 1982 was $36,681,000 and $32,170,000, respectively, including contributions to multiemployer plans.

NOTE F—Net Worth

The following is a summary of changes in net worth:

	1983	1982
Donated:		
Balance at January 1	**$ 28,758**	$ 25,239
Donations received	**1,026**	6,140
Less donations made	**165**	2,621
Balance at December 31	**29,619**	28,758
Retained income:		
Balance at January 1	**476,848**	408,744
Net income	**104,603**	73,842
Deduct—acquisitions (Note B)	**—**	5,738
Balance at December 31	**581,451**	476,848
Total Net Worth	**$611,070**	$505,606

NOTE G—Contingency

Actions alleging violation of federal antitrust laws have been commenced against Health Plans and Hospitals in federal courts in California on behalf of a purported class consisting of present and former owners of retail or community pharmacies in California, Oregon and Washington in areas served by the Kaiser-Permanente Medical Care Program, which actions pray for unspecified but potentially substantial treble damages. Health Plans and Hospitals made pretrial motions to dismiss the actions, which motions were granted by the District Court. The dismissal was reversed on appeal and the actions were returned to the District Court. Health Plans and Hospitals again made pretrial motions to dismiss the actions which were granted by the District Court on February 14, 1983. The plaintiffs have appealed. In the opinion of counsel, it seems probable that disposition of these actions will be within limits which, in the judgment of management, would not have a material effect on the combined financial position of Health Plans and Hospitals.

NOTE H—Increase (Decrease) in Working Capital Components

	December 31	
	1983	1982
Cash	**$101,048,000**	$(69,695,000)
Accounts receivable	**20,771,000**	31,629,000
Inventories	**1,868,000**	6,391,000
Prepaid expenses	**4,887,000**	1,957,000
Accounts payable and accrued expenses	**(53,010,000)**	(28,271,000)
Due to associated medical groups	**(16,817,000)**	(2,076,000)
Payroll and related charges	**(15,552,000)**	(18,559,000)
Liability for self-insured losses	**(10,127,000)**	(2,736,000)
Dues collected in advance	**(5,030,000)**	(6,805,000)
Revenue deferred to reduce dues rates	**(12,028,000)**	(4,230,000)
Other liabilities	**(14,430,000)**	(3,813,000)
Current installments on long-term debt	**(12,577,000)**	(916,000)
Decrease in Working Capital	**$(10,997,000)**	$(97,124,000)

TOUCHE ROSS & CO.
ONE MARITIME PLAZA
SAN FRANCISCO, CALIFORNIA

February 22, 1984

Boards of Directors
Kaiser Foundation Health Plan, Inc.
and Subsidiaries and
Kaiser Foundation Hospitals
Oakland, California

We have examined the combined balance sheets of Kaiser Foundation Health Plan, Inc. and Subsidiaries and Kaiser Foundation Hospitals as of December 31, 1983 and 1982, and the related combined statements of net income and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the combined financial statements referred to above present fairly the financial position of Kaiser Foundation Health Plan, Inc. and Subsidiaries and Kaiser Foundation Hospitals as of December 31, 1983 and 1982, and the results of their operations and the changes in their financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Touche Ross & Co.

Certified Public Accountants

APPENDIX B

The New York Times, Monday, December 17, 1984

SURGE OF PREPAID HEALTH PLANS

H.M.O. Cost Savings Cited

By Milt Freudenheim

Until recently, the prepaid medical plans known as H.M.O.'s were dismissed as relatively expensive aberrations that flourished mainly in California and among government employees. But they have expanded greatly of late, as major employers have become much more conscious of worker health costs.

The reason: Skyrocketing medical costs have now made H.M.O., or health maintenance organization, plans highly competitive—and often cheaper—than traditional medical insurance.

Riding the crest of what one medical economist calls "the early stages of an industrial revolution in health care," the H.M.O.'s have added 1.2 million members this year, bringing their estimated total enrollment to 15 million.

And the H.M.O.'s expect a further increase when new Medicare regulations take effect. Under the new rules, Medicare will pay H.M.O.'s directly for memberships for the elderly and disabled, a potential total of 30 million people. The Secretary of Health and Human Services, Margaret M. Heckler, sent the new regulations to the Office of Management and Budget this week for final review.

THE LARGEST H.M.O.'s

Ranked by enrollment on Dec. 31, 1983

Kaiser Health Plans	**4,416,480**
Cigna Healthplan Inc.	**663,096**
Prucare	**338,346**
HealthAmerica Corp.	**332,898**
Mexicare Health Plans, Inc.	**296,807**
U.S. Health Care Systems	**239,805**
Charter Med Inc.	**235,063**
Family Health Program	**147,677**
Share Development Corp.	**82,146**
Hancock/Dikewood Inc.	**72,846**

Source: Interstudy

Some H.M.O. executives are leery of getting deeply involved in business with the Government, but a spokesman for the prepaid plans, James F. Doherty, executive director of Group Health Association of America, welcomed the new regulations as "the major development since the enactment of Medicare."

H.M.O. members pay a set fee (the national average is $54 a month for individuals, $172 for families) and are typically assured of 100 percent coverage of most hospital and medical bills, plus extras such as free physical examinations.

Traditional medical coverages, such as Blue Cross and Blue Shield, are insurance plans: Subscribers, or their private physicians or hospitals, are reimbursed after treatment. Often the reimbursement does not fully cover the fees involved.

A 10-year study by the Rand Corporation reported in June that health costs of H.M.O. members were 25 percent lower than for people covered by the usual fee-for-service plans—largely, Rand said, because H.M.O. members were admitted to hospitals 40 percent less frequently.

Critics in the medical profession contend that by using hospitals less, H.M.O.'s stint on quality. But recent studies,

notably one at the prestigious Mayo Clinic in Minnesota, have shown wide geographical variations in hospital use. Many physicians have been joining, or forming, group practices and competing for employer health contracts by minimizing costs and using hospitals less.

To fight back, some traditional insurers have started their own H.M.O.'s. Blue Cross and Blue Shield associations have started 57 H.M.O.'s in 28 states, which have recruited 1.8 million members. Among the major insurers, Cigna Healthplan Inc., the largest investor-owned H.M.O., currently has 718,000 members in the West and South. Prudential Health Care Plan Inc. has 400,000 members for its Prucare system in 13 cities.

In a race to establish national networks, Kaiser Foundation Health Plan, Inc., the largest H.M.O., is spending $300 million on expansion this year, according to Robert J. Erickson, senior vice president. He said Kaiser plans to spend $2 billion in the next five years. From its California base, Kaiser has jumped to nine other states and the District of Columbia. It added 200,000 members this year, for a total of 4.6 million. Revenues passed $3 billion.

In 1985, Kaiser will add three more states, including New York, where it plans to expand the Westchester Community Health Plan, a small H.M.O. in White Plains.

Tax-Exempt Financing

Beginning in the early 1980's, Kaiser in California and other H.M.O.'s in Seattle and Cambridge, Mass., were able to obtain tax-exempt financing through state agencies, said Peter A. Wadsworth, vice president at Kidder, Peabody & Company's health finance group.

"From the investor point of view, H.M.O.'s have proven that they can grow fast and profitably," he said. "They get their money before they spend it, and the major companies each have revenues in excess of $100 million."

Mr. Wadsworth said that the restrictions on tax-exempt financing that go into effect Jan. 1 are not expected to adversely affect H.M.O.'s. However, the new tax revision proposals recently announced by the Treasury Department—which would curb tax-exempt financings for private use—could affect H.M.O.'s, although some experts believe that exceptions may be made for hospitals.

Mr. Wadsworth has tracked five investor-owned H.M.O.'s that have gone public since early 1963. According to Mr. Wadsworth and Kidder, Peabody, the five have done well by investors, although their stock prices have pulled back from late October, when they reached a peak.

The five stocks are: United States Health Care Systems, which has gone from an initial offering price (adjusted for a stock split) of $5.93 to $28, yesterday's close; HealthAmerica which has gone from $6.40 (adjusted for a stock split) to $14.75; Maxicare Health Plans, from $16 to $20; Independence Health Plan, from $13 to $18, and Peak Health Care, $10 to $11.75. All trade over the counter.

Private or foundation-owned H.M.O.'s cannot depend on stock offerings. The Health Insurance Plan of Greater New York Inc. raised $3.5 million in July with a tax-exempt offering through the New Jersey Health Facilities Financing Authority. Robert L. Biblo, H.I.P.'s president, said the money would go toward a new "multi-specialty ambulatory center" in Paramus, N.J.

New York Legislation

Such tax-exempt financing is not now available to H.M.O.'s in New York State, Mr. Biblo said. But the Legislature just passed a bill that will allow such financings. The bill awaits Governor Cuomo's signature.

"Our Long Island facilities are at capacity," he said. "Part of our problem is to get access to capital, similar to what nonprofit hospitals have now." While waiting, H.I.P. arranged a $35 million loan in October.

H.I.P., with 900,000 members, is the nation's second-largest H.M.O. It was started by Mayor Fiorello La Guardia, primarily for city employees, in 1944, long before the health maintenace organization label was invented during the Nixon Administration. H.I.P. has had "a surge of growth in the past four years," Mr. Biblo said, as private companies have begun offering H.I.P. to employees. "We now have a base of 3,000 accounts," he said.

'A Cottage Industry'

"Medical care is still an organized cottage industry," says Phillip N. Bredesen, chairman and chief executive officer of HealthAmerica in Nashville. HealthAmerica has moved into 26 metropolitan areas, mainly in medium-sized cities, Mr. Bredesen said. New Orleans, the last big city without an H.M.O., will lose that distinction next month, when Health-America and a competing chain, Maxicare Health Plans Inc., begin operations there.

"As the industry heats up and becomes more competitive, it is likely to be less so in those kinds of markets," Mr. Bredesen said. "All the big players are in Chicago."

'All Having Fun'

"They are all having fun here," said Frank Nicholson, secretary-treasurer of the Chicago-based Illnois Association of H.M.O.'s. Enrollment in Chicago rose by 49 percent in the year ending in July, he said.

Chicago, the home base of such pillars of the establishment as the American Medical Association and the American Hospital Association, had long been tough terrain for H.M.O.'s. Now this has changed. "More and more physicians and hospitals are knocking on the H.M.O. doors," said Mr. Nicholson, who is also vice president of Blue Cross and Blue Shield's HMO Illinois, the state's largest prepaid plan. "Most marketable hospitals and medical staffs have affiliated with one."

But until a few years ago, H.M.O.'s were "virtually outlawed in 38 states," recalled Mr. Doherty of the national trade association. "Some states used to require H.M.O.'s to maintain reserves similar to insurance companies. The A.M.A. had a rule against contract practice of medicine. H.M.O.'s boards were often required to have physician majorities."

Restrictions were pushed aside by Federal laws and the Supreme Court's 1975 Goldfarb decision that held the learned professions subject to antitrust law, said Alain C. Entheven, a professor of management in the Stanford University Graduate School of Business. He attributes the rapid growth of H.M.O.'s, in part, to "a large decline in the political and economic power of the medical profession" caused by the 65 percent increase in new doctors since 1960.